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ABSTRACT

This manual, which is intended for use in conducting individualized inservice training sessions for certified nurse aides employed in nursing homes and boarding homes throughout Maine, contains six learning modules designed to help health care workers better meet the needs of elderly nursing home residents who are challenged with mental illness. Presented first is an introduction to the manual that includes the following: discussion of the facilitator's role in inservice training, a list of suggested training strategies; and guidelines for using a four-step training process involving learning needs assessment, information gathering, program planning and implementation, and training evaluation. The learning modules, each designed to be presented in a 2-hour session, deal with the following topics: the normal aging process; loss, grief, death, and dying; depression; dysfunctional behavior; dementia; and communication. Each learning module contains some or all of the following: session overview; objectives; background information; lesson plans for guiding trainees through training exercises; exercises; answers to the exercises/activities; and student handouts. Concluding the manual is a glossary. (MN)

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Geriatric Education and Resource Outreach

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"Topics in Aging and Mental Health"

A TRAINING MANUAL

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CE 070 850

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INTRODUCTION

In 1986, the United States Department of Health and Human Services, Office of Human Development Services, Administration on Aging, approved a grant proposal from the Maine Department of Mental Health and Mental Retardation. The grant title was "Statewide Mobile Psychogeriatric Consultation and Education in Boarding and Nursing Care Facilities." The primary goal of this consultation and education was to assist health care workers more effectively address the needs of elderly residents challenged with mental illness. In the State of Maine, an estimated 40% of the total elderly boarding home population has a history of hospitalization for mental illness. Of the 9000 elderly nursing home patients, 21% have a diagnosed mental illness.

For a number of reasons, elderly persons in boarding and nursing homes have, historically, received little mental health care. Often, the sole responsibility for that care rests upon untrained or undertrained facility personnel. Training for direct care providers in nursing homes (Certified Nurse Aide courses) consists primarily of skills needed to maintain the proper physical and emotional patient environment, reporting and recording observations, providing assistance in personal hygiene, assisting in body movement and ambulation, assisting in nutrition and elimination, assisting in emergency situations, and helping registered professional nurses provide general patient care. Mental health issues affecting elderly persons are only briefly addressed in the current CNA curriculum in Maine. There are no formal educational requirements for boarding home personnel with the exception of a medication certification course.

The lack of training requirements in the area of mental health for boarding and nursing homes personnel has resulted in a critical lack of expertise in the area of psychogeriatrics. Very few training programs in aging and mental health are available to direct care providers. Programs that do exist are limited in duration, frequency of presentation and follow up. Accessibility is further diminished by limited staffing, especially in smaller facilities.

The project, known as the Geriatric Education and Resource Outreach (GE&RO), was developed to address these training needs by providing training teams to conduct individualized onsite inservices to each participating facility. Each team consisted of a registered nurse and a licensed social worker. A questionnaire was sent to 250 facilities statewide to determine the curriculum topics. The identified needs were grouped under the following six components:

Normal Aging Process

Grief, Loss, Death and Dying

Depression

Dysfunctional Behavior

Dementia

Communication

Each of these components was developed into a two hour training session. Six sessions were conducted at each participating facility, usually every other month, throughout the year. The series was presented to a total of 45 nursing and boarding care homes representing the variety of care settings that exist in the state. The largest facility was a 120 bed nursing home, the smallest a 6 bed family run boarding home.

This training manual represents the cooperative efforts of both GERO training teams. Because the modules were presented numerous times, they have undergone many revisions. While delivery time did not allow for the fullest development of the topics, the manual does reflect the program's concern that the materials included be relevant, practical, and as complete as time constraints permit. GERO is indebted to others in the field of aging and mental health who have developed and shared their training materials.

Finally, the manual reflects much of what we have learned from caregivers themselves. We have developed a new appreciation for those who serve elderly persons in the many boarding and nursing facilities across the state. We are indebted to those whose wages and recognition will never adequately reflect the contribution they make to the lives of those for whom they care. If training manuals had dedications, we would dedicate this one to these very special people.

GERO Training Manual produced under Grant Title:

"Statewide Mobile Psychogeriatric
Consultation and Education in Boarding
and Nursing Care Facilities"

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INTRODUCTION

TO MANUAL

The Geriatric Education and Resource Outreach Manual was designed to use as a guide for inservice development in both nursing and boarding homes. The modules address some of the emotional and mental health problems most commonly experienced by residents in these long term care facilities.

The curriculum was developed to facilitate training of Certified Nurses' Aides and other direct care staff in recognizing, understanding, and addressing needs of residents who function with a decreased ability to cope with emotional and mental health problems.

The modules are arranged in sequence from "Aging" to "Communication". They may be used as an ongoing series on aging and mental health or individually as a need is identified. Reading materials for the instructor and participants have been referenced at the end of each module to enhance the learning experience of all involved. Each module also includes prepared handouts and suggested methods as well as lecture material.

Instructors are encouraged to use these modules as a foundation upon which further experience and expertise can be built. The curriculum was designed to balance the development of skills in working with the mentally challenged elderly people with the exploration of personal feelings and attitudes toward aging and mental illness. Group discussions in conjunction with individual learning activities are emphasized. Shared responsibility for learning implies participation by learners as well as faculty.

FACILITATOR'S GUIDE

TO USE OF THE TRAINING MANUAL

Exploring new territory is often made easier with the use of a guide. A guide can show you the path that has been used successfully before. It can also help you avoid some of the pitfalls and common errors made by those who have gone before you. This guide has been developed to help you derive maximum benefit from the time you invest in using it.

We believe this manual can be helpful in assisting you to meet some of your staff's learning needs in the areas of aging and mental health. Because many of you are likely to be familiar with the nursing process approach to problem solving, we have used this as the model for this guide.

THE FACILITATOR ROLE

It can be intimidating to assume the task of conducting a workshop or inservice if you have had little or no prior experience in this area. Keep in mind that you are not expected to be an authority on any given topic. Your responsibility is to prepare yourself as well as possible through reading the manual, using other written resources, conferring with other people with knowledge of the topic, and drawing on your own experience. This may mean that you will not have the answers to all questions at your fingertips, but you will be able to guide people to other resources that could be helpful to them. You can also call upon the collective knowledge and experience of the group.

Facilitation means that you promote change and growth within the individual and the group. Your greatest expertise should come from an ability to create a climate that is supportive of **shared learning**. This means encouraging learners to take responsibility for meeting their own learning needs. In other words, you are responsible for establishing the learning environment; the participants are responsible for their own learning.

TRAINING STRATEGIES

The goal of training is to provide the participant with the skills and knowledge needed to do the job effectively. There are several training methods that you can use to achieve specific objectives. A few suggestions follow:

OBJECTIVE #1:

You would like participants to gain new facts and information.

Strategies: Discussion, mini-lectures, audio-visual materials, (slides, films, etc.), recordings, readings, handouts.

OBJECTIVE #2:

You would like participants to apply the new concepts or knowledge they have learned.

Strategies: Group discussion, demonstrations, case studies, participatory exercises, role playing.

OBJECTIVE #3:

You would like participants to practice performing physical skills and activities.

Strategies: Demonstration, practice, role playing, coaching.

OBJECTIVE #4:

You would like participants to examine and/or acquire helping attitudes, opinions, and values.

Strategies: Experience sharing, case study, role play, films, guided discussions.

TRAINING TERMS

AUDIO-VISUAL:

Describes various types of recordings, slides, films, movies and videos.

CASE STUDY:

Group discussion and problem solving based on an actual situation.

EXPERIENTIAL LEARNING:

Participants learn by participating in learning activities, followed by reflection on the activity.

HANDOUT:

Written materials prepared for participants to carry away from the training session.

LECTURRETTE OR "MINI-LECTURE":

A short lecture usually used to convey theory background or specific information.

ROLE PLAY:

Design for learning in which participants act out a situation through assigned parts that they play spontaneously.

SELF ASSESSMENT INSTRUMENTS OR TOOLS:

Anonymous questionnaires and check list requesting participants to examine and evaluate their own situations, needs, values, attitudes, or beliefs.

The use of this manual should provide an opportunity for your staff to increase their knowledge level and skills in the care of the elderly resident with mental health impairments. Because of its design and approach to the learning climate, we hope it will also serve to increase staff involvement in the team effort needed to provide care to the residents of your home.

You will note as you examine the manual that many opportunities are provided for staff at every level to actively participate by sharing their thoughts and experiences. This type of approach is generally successful when working with the adult learner. It may be helpful to review a few principles of adult education:

1. Adults bring with them to the class valuable knowledge, skills and experiences they have gained in their life experiences. Many learners, in a supportive environment, would be willing and anxious to share their experiences with the group. It can also be reassuring for you, as the facilitator, to know that the resources available to the group are not limited to those that you have. You will often have collective insight to draw from. Part of your role as facilitator is to know which contributions are therapeutic and which are not and to assist the group through the process of retaining and discarding information.

2. New lessons can be learned by reflection upon or discussion about one's life and work experience. This is very much a part of the learning process in these workshops. Not only will valuable insight be gained, but people will feel a part of the experience. Involvement in the learning process is critical if it is to be of value.

3. Adults learn best when they feel the content is going to be useful to them. They want and need to relate what they learn in the classroom to what they do on the job or experience in their personal life. While some new theory and knowledge is essential to each new learning experience, ways to apply this material to specific tasks at hand is an essential part of the program.

TRAINING GUIDE

STEP I

DEFINE THE LEARNING NEED

There are many ways to assess the learning needs of staff at your facility. Perhaps one of the easiest and most effective ways is to listen to the people who live and work at the home.

1. What kinds of issues are they discussing?
2. What are the problems they are identifying?
3. What behaviors are you observing?

Sometimes non-verbal communication may more honestly reflect needs than words. For example:

1. Is there a patient that staff avoid if at all possible?
2. Are the staff members treating the residents with the respect they are due?
3. Are staff feeling stressed by certain demands placed upon them by residents?

Keep on top on new regulations at your facility. Is there training that will be needed to abide by these new regulations? Take time to read the resident charts. Observe for accurate, timely, and descriptive notations. Be alert for new problems that are noted. Review resident care plans. Is there a need for new approaches to certain situations? Are all the needs of the residents being addressed, emotional, spiritual, social? Are changes in residents' behavior being addressed?

Once you have defined what the learning needs are, you may wish to share your observations with others on the administrative or clinical team. Finally, you need to define what is the desired outcome you would like to see.

STEP II

GATHER INFORMATION

Review the table of contents in each module. Note those units of information that most closely relate to the learning need you have identified. Review the learning objectives in the module and note the background information that relates to the topic you have chosen. Consider possible exercises that reinforce information.

Review references and/or bibliography for that module and select additional resources if necessary. Consult with the clinical staff available at your facility and keep in mind that the **GERO** staff is available to assist you in your program planning. You may also wish to review audio-visual resources available for loan to your facility.

STEP III

PLAN AND IMPLEMENT THE PROGRAM

Decide how much time you will need for the inservice. Choose a date and time that is most convenient to staff. You may wish to repeat the program so that the greatest number of staff can attend. Make sure to give plenty of advance notice. Refreshments create a receptive atmosphere if you can arrange for them.

Generally, a combination of learning approaches works best (see material on learning/teaching strategies). For example, a mini-lecture over essential background information, followed by an experiential exercise, guided group discussion, or case study might be a workable plan.

Move the program along. A change of pace every 15-20 minutes will help maintain an interest level among participants. Encourage participation from group members. Sharing experiences can be a valuable learning tool for participants. Your role as facilitator is to relate incidents in the experiences discussed to the topic at hand.

STEP IV

EVALUATION

Feedback from participants, either written or verbal, is the most pure and immediate evaluation possible. Long term evaluation would be measured by changes in behavior, i.e., reflecting an increase in knowledge and skills, as staff care for residents and relate to one another.

You may find that one session on a particular topic is not enough. You may then find it necessary to do further research at greater depth for the next inservice. Keep in mind that the **GERO** team is available to assist you in your work in this area.

The process of needs assessment and program evaluation is ongoing. Changes in your work environment will mean constant re-evaluation. As new staff, new residents, new regulations, and new administrations become part of your facility, new learning needs will emerge. The content areas will constantly be changing as more is learned about certain topics. Because the process of program planning and development will remain quite similar, you will have the opportunity to use the skills you are learning now many times over in future planning.

TRAINING PROCESS

EXAMPLE

STEP 1:

Identification of problem:

Several new residents are experiencing difficulty in adjusting to their move to the nursing/boarding home.

Learning need:

Staff want to know what they can do to assist the residents in making the transition to the care facility.

STEP 2:

Gather information:

Review Module #2 on **LOSS**, Section A and part of Section B. Review the learning exercises offered. Discuss the program with staff who may have special expertise in this area, i.e. social worker.

STEP 3:

Using the information you have gathered, plan your program. For a one hour inservice, you might consider the following formats as possible programs:

FORMAT #1

10 Minutes	Mini-lecture: Concept of loss in the elderly (from Section A and facility resources).
10 Minutes	Ten things I value most exercise.
30 Minutes	Video "Compassion I Suppose...."
10 Minutes	Group discussion of video.

FORMAT 2

15 Minutes	The Experience of Loss Worksheet - Complete and discuss in groups.
10 Minutes	Mini-lecture: Loss and the Elderly
35 Minutes	Loss and the Elderly Reaction Sheet and Discussion.

STEP #4:

Evaluation:

Obtain feedback by observing the response of participants to the program. You may wish to have them complete a very basic feedback form answering such questions as:

1. What did you find most helpful?
2. What was the least helpful part of the program?
3. What will be most helpful in your work?
4. How would you change the program?
5. What other topics would interest you?

The long term approach to evaluating the effectiveness of the program is to note changes in the behaviors that occurred before and after training. You will not expect to see startling results after only one or two programs, but you should see gradual change over time.

UNIT #1

AGING PROCESS

OVERVIEW

UNIT 1

AGING PROCESS

OVERVIEW

Unit #1, an introduction to the process of aging, addresses some of the basic physiological, psychological, and social factors that are involved with growing older. Normal aging is emphasized here in order to provide a basis for discussion about late-life mental and emotional problems which will be covered in subsequent units.

Section A helps participants to explore their personal attitudes, values, and beliefs about old age and looks at some of the more prevalent myths associated with growing older. Section B provides information about physiological, sensory, sexual, and cognitive changes. Section C addresses psychological and emotional changes and needs, particularly self esteem, self confidence and self worth.

Because the care provided to elderly persons is so significantly influenced by the personal values and beliefs of care givers, participants are continually encouraged to consider their own feelings about old age and the older people for whom they care.

OBJECTIVES:

SECTION A: To explore personal attitudes and beliefs about growing older and old age.

To identify and discuss myths and stereotypes surrounding old age.

SECTION B: To identify and discuss physiological and cognitive changes as they occur during the process of aging

To identify and discuss changes in sexuality as they occur during the process of aging

SECTION C: To identify and discuss late-life psychological changes and needs.

CONTENT:

SECTION A - Attitudes, Myths and Facts ....pp. 1-15

SECTION B - Physical and cognitive changes ....pp. 16-39

SECTION C - Psychological changes and needs ....pp. 40-49

SECTION A

ATTITUDES, MYTHS AND FACTS

CONTENT:

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Exercise #1 - Ground Breaking ....pg. 3
Exercise #2 - Guided Reminiscence ......pp. 4-5
Exercise #3 - Guided Meditation ....pp. 6-7
Exercise #4 - Myths and Facts Quiz .....pp. 8-15

ATTITUDES, MYTHS

AND FACTS

Background Information:

Although growing older is a fact of life, many of our attitudes about aging and old age are rooted in myths and misinformation.

Personal values and beliefs are shaped throughout life by individual experiences. Our attitudes about older people are often influenced most by our earliest experiences with such people as grandparents or other elderly relatives and neighbors. If the older people in those experiences were frail and disabled, as an adult you may perceive most older people to be the same (these perceptions may actually be reinforced if you work in a nursing or boarding home). However, if those experiences were with healthy and active older people, then you know that not all older people are frail and disabled. More than anything else, our attitudes about aging and old age influence the way in which we care for older people.

As a care giver you have a unique opportunity to continually shape your attitudes and beliefs about aging and old age from first-hand experiences. However, the work is often too demanding to allow you to slow down and get to know and enjoy each person as an individual. If you bring negative attitudes about old age to a job where you never get the time to be influenced otherwise, the effect on the quality of care that you provide is dramatic.

You are in the business of providing care because you do care, and you want to provide the best care that you can. It is vitally important that you stop and consider your own feelings and how your attitudes and beliefs affect that care.

The following exercises help participants to identify the sources of many of their attitudes about aging and old age. In addition, participants' perspectives on aging are broadened by discussion with fellow workers. Exercise #1 serves as an excellent icebreaker and conduit for introductions. Exercise #2 and #3 help participants to begin to understand the source of some of their own attitudes. Exercise #4 offers participants the opportunity to test their own knowledge about the differences between the myths and facts about aging and old age.

EXERCISE #1

GROUND BREAKING

OBJECTIVE:

Sometimes the most difficult part about conducting a training session that focuses on personal feelings is getting started. This exercise provides an excellent opportunity for co-workers to get to know each other a little better in a non-threatening way.

METHOD:

A chalkboard and chalk (or a flip chart, easel and marker) are most helpful for this exercise. If none are available, the presenter may wish to repeat the instructions throughout the course of the exercise.

Each participant answers the following questions aloud:

1. WHAT IS YOUR NAME?
2. WHAT IS YOUR ROLE AT THIS HOME?
3. HOW OLD WOULD YOU LIKE TO LIVE TO BE?
4. WHAT DO YOU FEEL IS ONE POSITIVE PART ABOUT GROWING OLDER?

Each individual is given a few moments to answer the questions in front of the group.

DISCUSSION:

This time may be used to highlight some of the facts about aging and to debunk some of the myths as they arise during discussion. This generally requires only gatekeeping by the facilitator. Participants are usually quite vocal about myths and facts, especially if there is a wide age span in the group.

TIME: 15-20 minutes

EXERCISE #2

GUIDED

REMINISCENCE

OBJECTIVE:

Some of our strongest beliefs and attitudes are formed by early childhood experiences. Our experiences with older people when we were children will greatly influence how we feel about older people as adults.

The purpose of this exercise is to discover which of our present day feelings and thoughts about old age were colored by experiences during childhood.

METHOD:

A quiet room, record player (or tape recorder) and music are needed for this exercise. The presenter should narrate slowly and clearly in order to help participants make an easy transition from the present into the past.

This is a visualization exercise. Soft music is played in the background to encourage relaxation. Participants are asked to take a trip back in time to the age of ten.

NARRATOR:

OUR FEELINGS ABOUT WHAT IT IS LIKE TO BE OLD, OR OUR SENSE OF HOW "OLD PEOPLE" ARE AND SHOULD BE WERE SHAPED BY MANY DIFFERENT INFLUENCES IN OUR LIVES. ONE OF THESE INFLUENCES MIGHT WELL HAVE BEEN EXPERIENCES WE HAD AS YOUNG CHILDREN.

WITH SOFT MUSIC AS A BACKGROUND, YOU WILL BE ASKED TO SIT BACK AND RELAX FOR A FEW MOMENTS, ALLOWING YOURSELF TO TAKE A SHORT TRIP BACK INTO YOUR CHILDHOOD. WE WILL GUIDE YOUR THOUGHTS JUST A BIT.

(turn on music)

PLEASE GET COMFORTABLE IN YOUR CHAIRS. RELAX YOUR BODY AND ENJOY THE MUSIC. CONCENTRATE ON YOUR BREATHING, TAKING SLOW DEEP BREATHS. AS YOU SLOWLY BLOW OUT YOUR TENSION, SAY THE NUMBER ONE TO YOURSELF.

(pause)
NOW LET'S TAKE A TRIP BACK IN TIME TO YOUR CHILDHOOD - ABOUT

THE TIME YOU WERE 10 YEARS OLD. TRY TO PLACE YOURSELF BACK IN TIME TO THAT PART OF YOUR CHILDHOOD (for a point of reference, age 10 is about 4th grade).

(pause)

NOW YOU ARE TEN YEARS OLD. THINK ABOUT AN OLDER PERSON THAT YOU KNEW AT THAT TIME. IT MIGHT BE A GRANDPARENT, FAMILY FRIEND, SOMEONE WHO RAN THE GROCERY STORE. CHOOSE SOMEONE YOU KNEW WELL AND SOMEONE WHO WAS A SIGNIFICANT PERSON IN YOUR LIFE.

(pause)

NOW TRY TO REMEMBER A SPECIFIC SITUATION THAT HAPPENED WITH THIS OLD PERSON. REMEMBER IT IN AS MUCH DETAIL AS YOU CAN. TRY TO RECAPTURE THE FEELINGS THAT YOU EXPERIENCED DURING THIS EVENT.

(pause)

NOW THAT YOU HAVE RECAPTURED THIS EXPERIENCE, BEGIN TO COME BACK TO THE PRESENT TIME. YOU CAN HEAR THE SOUNDS OF THE HERE AND NOW AROUND YOU. OPEN YOUR EYES, SIT UP. MOVE AROUND A BIT IF YOU WISH.

LET'S TAKE A FEW MOMENTS TO SHARE SOME OF OUR EXPERIENCES AND TO THINK ABOUT THE INFLUENCE THESE EXPERIENCES MIGHT HAVE HAD ON US AS WE GREW OLDER.

DISCUSSION:

Participants are asked to bring this special memory back with them to the present time. Look for volunteers to share their stories. Be prepared to share a personal anecdote if no volunteers emerge. Emphasis is placed on the many different ways older people have touched our lives.

If people are hesitant to share, consider using the unfinished sentence approach.

Suggested sentences include:

a) I was surprised to find that ......
b) I was happy that ....
c) It was a little sad when ....
d) I enjoyed thinking back to ....
e) I did not enjoy ....

Time: 25-30 minutes

EXERCISE #3

GUIDED MEDITATION

OLD AGE

OBJECTIVE:

To allow participants to visualize and understand their feelings about their own aging.

METHOD:

Facilitator leads group in 3-5 minutes of relaxation exercises (eyes closed, slow, deep breathing, etc.). Participants are asked to keep their eyes closed throughout the exercise.

NARRATOR:

IN A MINUTE... WE'RE GOING TO GO AN A WALK THROUGH A FIELD. LET YOURSELF BE STANDING RIGHT NOW AT THE EDGE OF A FIELD. PICTURE THAT FIELD...IT COULD BE ONE THAT YOU KNOW ABOUT...OR ONE PURELY IN YOUR IMAGINATION. NOTICE WHETHER THE FIELD IS VAST...OR SMALL...IS IT GRASSY OR BARREN. NOW TAKE A LOOK AROUND YOUR IMMEDIATE ENVIRONMENT..NOTICE WHETHER ANYTHING IS GROWING...WHAT THE TERRAIN IS LIKE...LOOK OFF IN THE DISTANCE...HOW FAR CAN YOU SEE...IS IT DAY OR NIGHTTIME AND HOW CAN YOU TELL? BE AWARE OF WHAT THE ATMOSPHERE IS LIKE...FEEL THE TEMPERATURE OF THE AIR. TAKE A DEEP BREATH, IN YOUR IMAGINATION...BE AWARE OF ANY SMELLS IN THE FIELD. WHAT SOUNDS DO YOU HEAR? NOTICE HOW YOU ARE FEELING AS YOU WALK THROUGH THAT FIELD...WHAT EMOTIONS ARE YOU EXPERIENCING...WHAT THOUGHTS ARE GOING THROUGH YOUR HEAD?

NOW...NOTICE A PATH STRETCHING OUT IN FRONT OF YOU. KEEP WALKING ALONG...NOW...YOU HAVE COME TO A FENCE THAT CROSSES THE FIELD. IN FRONT OF YOU, YOU WILL SEE A GATE. REACH OUT...OPEN THIS GATE...WALK THROUGH IT. CLOSE THE GATE BEHIND YOU. ON THIS SIDE OF THE FENCE YOU ARE AN OLD PERSON. OBSERVE HOW YOUR BODY IS CHANGING HOW IS IT DIFFERENT FROM BEFORE? LET YOURSELF BECOME AWARE OF HOW THE FIELD LOOKS ON THIS SIDE OF THE FENCE. WHAT IS IT LIKE ON THIS SIDE? FEEL THE ENERGY OF THE FIELD ON THIS SIDE. RECORD IN YOUR MIND WHAT YOU SEE ABOUT YOU. MOVE DOWN THE PATH TOWARD A SMALL POND AHEAD OF YOU. OBSERVE YOUR MOVEMENTS AS YOU GO...ARE THEY QUICK OR ARE THEY SLOW? HOW DOES YOUR BODY FEEL AS IT MOVES? WHEN YOU ARRIVE AT THE POND, GAZE DOWN INTO THE CLEAR WATER...NOTICE HOW YOUR FACE REFLECTS IN THE WATER. HOW DOES IT LOOK? HOW HAS YOUR FACE CHANGED...YOUR HAIR...YOUR FEATURES...NOW NOTICE THE TRUNK OF YOUR BODY...SEE WHETHER IT IS THIN OR FAT...NOTICE THE SHAPE AND COLOR OF YOUR ARMS...YOUR HANDS.

EXAMINE HOW YOUR BODY FEELS INSIDE...IS ANY SPECIAL PART PARTICULARLY NOTICEABLE TO YOU? DOES ANY PART OF YOUR BODY HAVE PAIN...OR CAUSE YOU PARTICULAR CONCERN?

NOW...REST BY THE POND AND CONTEMPLATE WHAT YOUR LIFE IS LIKE. HOW DO YOU SPEND YOUR DAYS? WHAT BRINGS YOU JOY IN YOUR LIFE? DO YOU HAVE FEARS ABOUT ANYTHING? WHO ARE YOUR COMPANIONS? WHAT ARE YOU FEELING LIKE RIGHT NOW IN YOUR BODY AND YOUR MIND?

NOW...TURN AROUND AND MOVE BACK AGAIN TOWARD THE FENCE THAT WAS BEHIND YOU. FIND THE GATE THAT YOU WENT THROUGH BEFORE...OPEN IT AND PASS THROUGH IT ONCE MORE. NOW YOU ARE THE AGE THAT YOU WERE WHEN YOU ENTERED THIS ROOM. OBSERVE HOW THAT CHANGE FEELS TO YOU. TAKE ANOTHER MINUTE TO NOTICE YOUR FEELINGS. WALK AGAIN DOWN THE PATH AND RETURN AGAIN TO THE EDGE OF THE FIELD WHERE YOU STARTED FROM. NOW...SLOWLY...TAKING AS MUCH TIME AS YOU NEED...RETURN TO THIS ROOM. WHEN IT FEELS LIKE THE RIGHT TIME...STRETCH...OPEN YOUR EYES...SIT UP.

DISCUSSION:

A) Were people able to visualize much of the time?

B) What part was most vivid to you?

C) Did you find that the field changed after you walked through the gate?

D) How did you change when you became old on the other side of the gate?

E) What was the most emotionally charged part of this exercise?

F) Did anyone have any new insights or experiences with aging that they hadn't had before?

G) Did anything happen that really surprised you...either visually or in your feelings?

H) What were the feelings that happened? (facilitator can use brainstorming technique)

TIME: 25-30 minutes

EXERCISE #4

MYTHS AND FACTS

QUESTIONNAIRE

OBJECTIVE:

The purpose of this exercise is to focus on some of the more prevalent myths about growing older. Accurate information is provided to emphasize that aging is an individual process that proceeds differently for each person, and that it is unwise to make assumptions about a person on the basis of his or her age alone.

This exercise also emphasizes that many phenomena that we once believed to be part of normal aging are actually the result of disease processes. This means that how we live our lives now may, in large part, determine the quality of our lives in later years.

METHOD:

For this exercise the enclosed Myths and Facts on Aging Questionnaire is required. Participants are asked to complete the questionnaire individually and to discuss their answers as a group. The presenter facilitates the discussion using the enclosed answer sheet as a guide.

DISCUSSION:

Several variations of this questionnaire may be used for this exercise depending on the needs of the group. Either the entire quiz or only a few questions may be used.

TIME:

Take as much time as is needed for this exercise. Debunking myths about aging may be the most important training you will ever do.

MYTHS AND FACTS QUESTIONNAIRE

T F 1. THE MAJORITY OF OLD PEOPLE, i.e., past age 65 ARE SENILE e.g., defective memory, disoriented, or demented.

T F 2. ALL FIVE SENSES TEND TO DECLINE IN OLD AGE.

T F 3. MOST OLD PEOPLE HAVE NO INTEREST IN, OR CAPACITY FOR, SEXUAL RELATIONS.

T F 4. LUNG CAPACITY TENDS TO DECLINE IN OLD AGE.

T F 5. THE MAJORITY OF OLD PEOPLE TEND TO FEEL MISERABLE MOST OF THE TIME.

T F 6. PHYSICAL STRENGTH TENDS TO DECLINE IN OLD AGE.

T F 7. AT LEAST ONE-TENTH OF AGED PEOPLE ARE LIVING IN LONG-STAY INSTITUTIONS, i.e., nursing homes, mental hospitals, homes for the aged.

T F 8. AGED DRIVERS HAVE FEWER ACCIDENTS PER PERSON THAN DRIVERS UNDER AGE 65.

T F 9. MOST OLDER WORKERS CANNOT WORK AS EFFECTIVELY AS YOUNGER WORKERS.

T F 10. ABOUT 80% OF AGED PEOPLE ARE HEALTHY ENOUGH TO CARRY OUT THEIR NORMAL ACTIVITIES.

T F 11. MOST OLD PEOPLE ARE SET IN THEIR WAYS AND UNABLE TO CHANGE.

T F 12. OLD PEOPLE USUALLY TAKE LONGER TO LEARN SOMETHING NEW.

T F 13. IT IS ALMOST IMPOSSIBLE FOR MOST OLD PEOPLE TO LEARN NEW THINGS.

T F 14. THE REACTION TIME OF MOST OLD PEOPLE TENDS TO BE SLOWER THAN THE REACTION TIME OF YOUNGER PEOPLE.

T F 15. IN GENERAL, MOST OLD PEOPLE ARE PRETTY MUCH ALIKE.

T F 16. THE MAJORITY OF OLD PEOPLE ARE SELDOM BORED.

T F 17. THE MAJORITY OF OLD PEOPLE ARE SOCIALLY ISOLATED AND LONELY.

T F 18. OLDER WORKERS HAVE FEWER ACCIDENTS THAN YOUNGER WORKERS.

T F 19. OVER 15% OF THE U.S. POPULATION ARE NOW AGED 65 OR OLDER.

T F 20. MOST MEDICAL PRACTITIONERS TEND TO GIVE LOW PRIORITY TO AGED PEOPLE.

T F 21. THE MAJORITY OF OLDER PEOPLE HAVE INCOMES BELOW THE POVERTY LEVEL.

T F 22. THE MAJORITY OF OLDER PEOPLE ARE WORKING OR WOULD LIKE TO HAVE SOME KIND OF WORK TO DO.

T F 23. OLDER PEOPLE TEND TO BECOME MORE RELIGIOUS AS THEY AGE.

T F 24. THE MAJORITY OF OLDER PEOPLE ARE SELDOM IRRITATED OR ANGRY.

T F 25. THE HEALTH AND SOCIOECONOMIC STATUS OF OLDER PEOPLE IN THE YEAR 2000 WILL PROBABLY BE ABOUT THE SAME AS IT IS NOW.

T F 26. AS PEOPLE GROW OLDER, THERE IS OFTEN A DECREASE IN KIDNEY FUNCTION.

T F 27. USUALLY THERE ARE NO CHANGES IN THE SLEEP PATTERNS OF OLDER PEOPLE.

Adapted from Palmore, Erdmine, "Facts on Aging; A Short Quiz", **The Gerontologist**, September, 1977.

ANSWERS TO MYTHS AND FACTS QUESTIONNAIRE

#1 - THE MAJORITY OF PEOPLE PAST THE AGE OF 65 ARE SENILE

False. Senility is not a natural condition of aging. In fact "senility" isn't even a legitimate medical diagnosis, but a word used by many to describe confusion and forgetfulness when they occur in an older person. Though these symptoms can occur at any time in life, they are mistakenly thought of as being age-related rather than illness-related.

#2 - ALL FIVE SENSES TEND TO DECLINE IN OLD AGE

True. Most studies agree that various aspects of vision, hearing and touch tend to decline in old age. Additional evidence indicates decreases in taste and smell thresholds. The most notable decline is in vision and hearing. An awareness of sensory loss and its impact on behavior can improve the effectiveness of those who work with the elderly.

Normal sensory loss is **gradual**. Most of the information that goes into a person's brain comes directly from one of the five senses. Impairment of any sense can have an effect on behavior, but this is most significant with vision and hearing loss. Vision impairment can greatly increase the possibility of physical harm from accidents. In addition, individuals may become isolated from activities they once enjoyed. Isolation and withdrawal can be the beginning of emotional problems. Hearing loss can also lead to feelings of paranoia. Withdrawal, depression, isolation, confusion, and agitated behavior can all occur secondary to hearing loss. Hearing loss is more difficult for people to acknowledge early on when it can be evaluated and treated.

#3 - MOST OLD PEOPLE HAVE NO INTEREST IN OR CAPACITY FOR SEXUAL RELATIONS

False. Masters and Johnson found that the capacity for satisfying sexual relations continues into the decades of the seventies and eighties for healthy couples. Discussion then focuses on what does change for the older person.

Factors to consider are a) negative stereotyping by society; b) attitudes and values of older persons themselves; c) physical conditions, chronic illness; d) discomfort of staff in long-term care settings; and e) absence of partners.

Sexuality also needs to be addressed in its broader definition. Sexuality includes physical and emotional closeness, touching and caressing, feeling "as one" with another person, and finally the opportunity to both give and receive love.

(Discussion concerning the legitimacy of feelings and how these are appropriately or inappropriately expressed in a long term care setting should happen at this point)

#4 - LUNG CAPACITY TENDS TO DECLINE IN OLD AGE

True. Lung capacity does tend to decline in old age. Both vital lung capacity (the volume of air that can be forcibly expelled in one breath) and maximum breathing capacity (the volume of air that can be moved in and out of the lungs in 15 seconds) declines on the average from age 30 onward.

#5 - THE MAJORITY OF OLD PEOPLE FEEL MISERABLE MOST OF THE TIME

False. The majority of old people do not feel miserable most of the time. Studies of happiness, morale, and life satisfaction either find no significant difference by age groups or find about one-fifth to one-third of the aged score "low" on various happiness or morale scales. A recent national survey found that less than a fourth of persons 65 or over reported that "this is the dreariest time of my life"; while a majority said "I am just as happy as when I was younger.

#6 - PHYSICAL STRENGTH TENDS TO DECLINE IN OLD AGE

True. Studies of various kinds of muscle strength show decline in old age as compared with young adulthood. Once again, this is a very individual change, with degrees of loss varying from person to person. Loss of strength can make people slower and weaker. Though people need more time to get things done, it is essential that they be encouraged to continue to do as much as possible for themselves.

#7 - AT LEAST ONE-TENTH OF AGED PEOPLE ARE LIVING IN LONG-TERM CARE INSTITUTIONS

False. Fewer than 5% of persons 65 or over are residents of long-term care facilities. Even among those age 75 or over, fewer than 10% are residents in institutions.

#8 - AGED DRIVERS HAVE FEWER ACCIDENTS PER PERSON THAN DRIVERS UNDER AGE 65

True. Drivers over age 65 do have fewer accidents per person than drivers under age 65. Older drivers have about the same accident rate per person as middle aged drivers, but a much lower rate than drivers under age 30. Older drivers tend to drive fewer miles per year and apparently tend to compensate for any declines in perception and reaction speed by driving more carefully.

#9 - MOST OLDER WORKERS CANNOT WORK AS EFFECTIVELY AS YOUNGER WORKERS

False. The majority of older workers can work as effectively as younger workers. Despite declines in perception and reaction speed under laboratory conditions among the general aged population, studies of older workers under actual working conditions generally show that they perform as well as, if not better than younger workers on most measures. When speed of reaction is important, older workers sometimes produce at lower rates, but they are at least as accurate and steady in their work as younger workers. Consistency of output tends to increase by age, as older workers perform at steadier rates from week to week than younger workers do. In addition, older workers have less job turnover, fewer accidents and less absenteeism than younger workers.

#10 - ABOUT 80% OF ELDERLY PEOPLE ARE HEALTHY ENOUGH TO CARRY OUT THEIR NORMAL ACTIVITIES

True. About 5% of people over 65 are institutionalized at any given point in time. Another 15% say that they are unable to carry out major tasks of daily living independently. Poor health does not prevent the remaining 80%, the vast majority, from performing normal activities of daily living.

#11 - MOST OLD PEOPLE ARE SET IN THEIR WAYS AND ARE UNABLE TO CHANGE

False. The majority of old people are not "set in their ways and unable to change." There is some evidence that older people tend to become more stable in their attitudes, but it is clear that most older people do change and adapt to the many major events that occur in old age such as retirement, children leaving home, widowhood, moving to new homes, and serious illness. Their political and social attitudes also tend to shift with those of the rest of society, although at a somewhat slower rate than for younger people.

#12 - OLD PEOPLE USUALLY TAKE LONGER TO LEARN SOMETHING NEW

True. Experiments have consistently shown that older people take longer than younger people to learn new material. Studies of on-the-job trainees also show that older workers tend to take somewhat longer to learn new jobs.

#13 - IT IS ALMOST IMPOSSIBLE FOR OLD PEOPLE TO LEARN NEW THINGS

False. While learning new things may take a little longer, studies have consistently shown that older persons can definitely learn new things. One principle of adult learning to keep in mind is that adults are far more likely to learn something new if they feel that it will be useful to them. This could be incorrectly interpreted as disability rather than disinterest.

#14 - REACTION TIME OF OLDER PEOPLE TENDS TO BE SLOWER THAN REACTION TIME OF YOUNGER PEOPLE

True. The increases become more noticeable as the situations become more complex. Reaction time differs from one person to another. In many situations people compensate for a slower reaction time by being more cautious, i.e., in driving.

#15 - IN GENERAL, MOST OLDER PEOPLE ARE PRETTY MUCH ALIKE

False. There appears to be at least as much difference between older people as there is at any other age. In fact, as people age, they tend to become less alike and more heterogeneous in many dimensions.

#16 - THE MAJORITY OF OLD PEOPLE ARE SELDOM BORED

True. Only 17% of persons 65 or over say "not enough to do to keep busy" is a "somewhat serious" or "very serious" problem. Another survey found that two-thirds of aged people said they were never or hardly ever bored. The Duke Adaptation study found that 87% of those 65 or over said they were never bored in the past week.

#17 - THE MAJORITY OF OLD PEOPLE ARE SOCIALLY ISOLATED AND LONELY

False. About two-thirds of aged people say they are never or hardly ever lonely, or say that loneliness is not a serious problem. Most older persons have close relatives within easy visiting distance and contacts between them are relatively frequent. About half say they "spend a lot of time" socializing with friends. About three-fourths of aged people are members of a church or synagogue, and about half attend services at least three times per month.

#18 - OLDER WORKERS HAVE FEWER ACCIDENTS THAN YOUNGER WORKERS

True. Most studies agree this is true. For example, a study of 18,000 workers in manufacturing plants found that workers beyond age 65 have about one-half the rate of non-disabling injuries as those under 65, and older workers have substantially lower rates of disabling injuries.

#19 - OVER 15% OF THE U.S. POPULATION ARE NOW AGED 65 OR OLDER

False. Approximately 12% of the population were age 65 or over in 1986 and this will probably not increase to more than 13% by the year 2000, even if completed fertility drops to zero population growth levels.

#20 - MOST MEDICAL PRACTITIONERS TEND TO GIVE LOW PRIORITY TO THE AGED PEOPLE

True. A series of 12 empirical studies all found that most medical students and doctors, nursing students and nurses, occupational therapy students, psychiatry clinic personnel, and social workers tend to believe the negative stereotypes about aged people and prefer to work with children or younger adults rather than elderly people. Few specialize, or are interested in specializing in geriatrics.

#21 - THE MAJORITY OF OLD PEOPLE HAVE INCOMES BELOW THE POVERTY LEVEL

False. The majority of older people have incomes well above the poverty level. In 1975, there were only 15.3% of elderly people below the official poverty level. Even if the "near poor" are included, the total in or near poverty is only 25.4%.

#22 - THE MAJORITY OF OLDER PEOPLE ARE WORKING OR WOULD LIKE TO HAVE SOME TYPE OF WORK TO DO

True. Over three-fourths of old people are working or would like to have some kind of work to do. There are about 12% of persons 65 or over who are employed, 21% who are retired but say that they would like to work, 17% who work as housewives, 19% who are not employed but do volunteer work, and another 9% who are not employed and not doing volunteer work. These percentages total 78%.

#23 - OLDER PEOPLE TEND TO BECOME MORE RELIGIOUS AS THEY AGE

False. While it is true that the present generation of older persons tends to be more religious than the younger generation, this appears to be a generational difference (rather than an age difference) due to older persons' more religious upbringing. In other words, the present older generation has been more religious all their lives rather than becoming more religious as they aged.

#24 - THE MAJORITY OF OLD PEOPLE ARE SELDOM IRRITATED OR ANGRY

True. A Kansas City study found that over one-half aged people said they are never or hardly ever irritated and this proportion increases to two-thirds at age 80 or over. About three-fourths said they are never or hardly ever angry. The Duke adaptation study found that 90% of persons over age 65 said they were never angry during the past week.

#25 - THE HEALTH AND SOCIOECONOMIC STATUS OF OLDER PEOPLE IN THE YEAR 2000 WILL PROBABLY BE THE SAME AS IT IS NOW

False. The health and socioeconomic status of the older population will probably be much higher than now. Measures of health, income, occupation, and education among older people are all rising in comparison to those of younger people. By the year 2000, the gaps between older and younger persons in these dimensions will probably be substantially less.

#26 - AS PEOPLE GROW OLDER, THERE IS OFTEN A DECREASE IN KIDNEY FUNCTION

True. Many persons over seventy years of age have lost as much as

30% of normal kidney function. This is important to remember when giving medications. Drugs can more easily accumulate in the system potentiating increased side effects and/or toxic reactions. The elimination half-life of psychotropic medications often increases with age in part because of reduced clearance associated with diminished organ functioning.

#27 - USUALLY THERE ARE NO CHANGES IN THE SLEEP PATTERNS OF OLDER PERSONS

False. The quality of sleep deteriorates with age. Most older people do not have a problem falling asleep but experience difficulty in staying asleep. Sleep is more fragmented with frequent and long periods of wakefulness occurring during the night. The amount of stage IV sleep is less or absent. Sedation does not help. It can, in fact, contribute to reverse sleep patterns, wakefulness at night with sleeping during the day.

SECTION B

PHYSICAL AND COGNITIVE CHANGES

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PHYSIOLOGICAL

CHANGES

Background Information:

Physiological changes are continual throughout life, but the rate and extent to which they occur is never identical in two persons. For some, physiological changes may never inhibit their ability to lead healthy and active lives, while for others late-life physiological changes may lead to decreased physical capabilities and the ability to function independently. Among the more important changes that may occur as a result of physiological aging are 1) a reduced ability to cope with physical and/or emotional stress; 2) slower healing, or the need for more time to recover from stress; and 3) a reduced ability to cope with changes in the environment.

Changes in skin and hair are very common in later years. Sags and wrinkles, which are probably the most visible characteristics of the aging process, are the result of a loss in the skin's elasticity. Dryness and changes in skin texture are due to a loss of body fluids and fatty tissue. Increased paleness and the appearance of "age spots" occur as a result of the loss of pigmentation cells. The loss of pigmentation also leads to grey hair, and while hair tends to thin among both sexes, balding is more common among older men. Hormonal changes may result in increased facial hair, particularly among women.

Changes in the muscular composition of the body tend to diminish physical strength in later years. The loss of physical strength and muscle deterioration tend to be more significant among inactive persons. Some loss of flexibility or stiffening of joints is also normal in aging, but problems like osteoarthritis and Rheumatoid arthritis lead to serious degeneration of the back, knees, hips, and other large joints.

During later years, bones become dryer and more brittle as a result of the loss of much of their calcium and other important fluids. Fractures, particularly hip fractures (which are especially common among older women), are very common, and fractured bones take much longer to mend. Osteoporosis, which leads to severe curvature of the spine and an increased susceptibility to fracture, is the most prevalent of all bone disorders among the elderly and is due to the decreased density in skeletal composition. Recent studies demonstrate that exercise prevents this decrease and that oral intake of calcium by post-menopausal women also reduces calcium resorption in bone.

The muscles that operate the heart weaken in later years while the tissue in the chest cage stiffens, resulting in the diminished capacity of the lung to expand. This results in the need for increased energy to maintain proper ventilation of the respiratory system. Also, as a result of a decreased ability to fight off infections, respiratory diseases, which include Bronchitis, Emphysema and Lung Cancer, are particularly prevalent among older people. The heart also shrinks with age while fatty tissues increase in the arterial walls. Valves become more rigid and thick, decreasing the accuracy of their functioning. In later years the heart reacts less effectively to stress which slows its rate of recovery. The heart's ability to use oxygen is also reduced and blood flow through the coronary artery is decreased substantially.

Of the current U.S. population of about 241 million, nearly 66 million (more than one in four) Americans suffer from some form of cardiovascular disease (high blood pressure, heart attack, stroke and rheumatic heart disease).

The greatest number of these (60,130,000) suffer from hypertensive disease (high blood pressure.) Hypertension contributes to heart attacks, strokes, and atherosclerosis. Age is a risk factor in hypertension. Generally speaking, the older people get, the more likely they are to develop high blood pressure.

EXERCISE #1

INVENTORY OF PHYSICAL CHANGES

OBJECTIVE:

To explore participants' knowledge of the physical aspects of normal aging processes and to facilitate discussion about those changes.

METHOD:

Facilitator asks group to "brainstorm" on physical changes that occur in "old age." Using a chalkboard (or newsprint) a list of responses is generated for discussion.

DISCUSSION:

The facilitator may choose to review all responses individually, providing accurate information on each, or to identify a few key responses for discussion using supplemental handouts.

In addition to providing information about the physical changes associated with aging, this exercise provides an excellent opportunity to emphasize the differences between normal aging and changes that are the result of illnesses or disease and to dispel common myths about growing older.

TIME: 20-25 minutes

EXERCISE #2

MOBILITY IMPAIRMENT

OBJECTIVE:

To sensitize participants to losses in mobility that can occur with advanced age and to the feelings that often accompany those losses.

METHOD:

Materials needed: Geriatric chair with lock-arm restraints or wheel chairs.

Facilitator selects a few volunteers from the group to be "immobilized" in chairs and placed away from the group (while remaining in visual contact). While volunteers are immobilized and isolated, the facilitator leads the group in some kind of general discussion, or group activity for about 10-15 minutes. At the end of the activity volunteers are asked to share their feelings about the experience.

DISCUSSION:

A) What did volunteers notice about the passage of time?

B) From their positions of immobility what did the volunteers observe about other immobile volunteers?

C) What did volunteers notice about non-confined participants?

D) Did mobility have any effect on need gratification?

E) What did volunteers notice about their own physical comfort?

F) Was there any increase in daydreaming or fantasizing as a result of mobility?

TIME: 20-25 minutes

*** Note To Trainer**

This exercise is most effective if non-confined participants are led in some kind of physical activity, such as a stretching exercise, while volunteers are confined.

HANDOUT #1

PHYSICAL CHANGES IN AGING

I. **Skin:**

A. Becomes less elastic and more wrinkled

B. Hair turns grey

C. Facial hair increases, especially in women

D. Loss of pigmentation creates "aging" spots - these are brown in light skinned persons and lighter in dark skinned persons.

II. **Musculoskeletal System**

A. Muscle atrophy, leading to general complaints of weakness

B. Joints undergo degenerative changes

Osteoarthritis (wear and tear) of back, hips, knees and larger joints is common

Pain is not always present

C. Bones deteriorate and become brittle (osteoporosis)

Hip fractures, due to osteoporotic bone, are common, particularly among women (30-40% of women develop osteoporosis)

Shrinking of the intervertebral discs cause shortening of stature

D. Reaction time and reflex action slows

Decreases 15% by age 80

Men have greater decreases than women

III. **Respiratory System**

A. Decrease in maximum breathing capacity, inability to breathe as effectively

B. Increased shortness of breath on exertion

C. Pulmonary disease becomes increasing prevalent as a result of interactions between normal biological changes and environmental impacts

D. Remember that chronic respiratory symptoms are not normal

IV. **Cardiovascular System**

A. Cardiac reserve diminishes (affects ability to handle stress)

B. Cardiac output decreases, heart rate decreases

C. Maximum blood flow through coronary artery decreases by 35% by age 60

D. Degenerative vascular disease is age-related

V. **Gastrointestinal System**

A. Common cause of chronic distress in older people, with one-half of all complaints being functional without an organic basis

B. Changes in bowel habits are common, as is constipation

C. Changes are affected by poor teeth and dentures

D. Poor nutritional intake is common, compounded by sensory changes in taste sensations

E. Emotional and behavior patterns have a great impact

VI. **Genito-Urinary System**

A. Changes in sexual responsiveness but physical capability continues

B. Diminished muscle tone

C. Increased frequency of urination

D. Prostate gland problems

SENSORY CHANGES

Background:

Information about the environment is sent to the brain through the five senses: sight, hearing, touch, taste and smell. All throughout life, sensory abilities change significantly. During later years those changes have an enormous impact on quality of life.

Vision

The lens of the eye hardens throughout life but doesn't usually begin to cause vision problems until around age 40. The main difficulty is a decreased ability to focus on close objects. It is at this time that an individual may, for the first time, need glasses. For those who already wear glasses, stronger lenses may be needed.

In addition, a decreased amount of light that enters the eye makes it more difficult to see objects in the dark. Often times older people will need more light for reading. Changes in the ability to see the difference between some colors, particularly between blues and greens, also occur in later years as does the ability to distinguish depth. The result of these changes may include poor mobility and spatial orientation and may even result in some visual hallucinations as well. Intraocular pressure may rise, a sign of glaucoma. All persons over 40 should have this tested yearly.

Hearing

The breakdown and loss of cells in the inner ear usually begins around age 30. This results in two kinds of hearing loss, the ability to hear some higher pitched sounds and the ability to hear balanced noise. While this varies greatly between individuals, as age increases the range of notes being heard may decrease. Hearing loss greatly interferes with social interaction, causing isolation and withdrawal.

Taste and Smell

Older people are less able to taste and smell. Taste buds on the tongue tend to decrease by 1/3 between the ages of 30 and 70. Also mucous membranes secrete less, causing increased dryness in the mouth. Sweet and salty tastes tend to decrease first, followed by bitter and sour. In the sense of smell, the richness of information that gets sent to the brain tends to fall off quicker than the sense of taste. Men tend to loose the sense of smell and taste sooner than women.

Because of the decrease in the ability to taste and smell, many older people lose interest in eating some foods. Loss of appetite may lead to malnourishment which may lead to serious physical and mental health problems.

Touch

Changes in the skin and muscles affect the sense of touch in later years. The inability of an older person to manipulate some objects may be the result of a loss of fine motor control which may also affect the ability to identify certain textures. Frequently, the loss of touch and sensation is due to a central nervous system problem.

Another result of changes in the ability to touch may be the loss of sense of pain. This can be a serious problem for some older people who hurt themselves, e.g., burning while cooking, lacerations, without realizing it. Burns and lacerations that go undetected may cause additional serious problems later on.

VISUAL SENSORY

DEPRIVATION

OBJECTIVE:

To allow participants to experience the loss of vision

METHOD:

Materials needed: Blindfolds

Participants form groups of two. One member is blindfolded while the other leads him/her on a walk for about 15-20 minutes, during which time there should be no verbal communication. The "sighted" participant must indicate (without talking) positive aspects of the environment to be experienced by the "blind" partner as well as the dangers. Roles are reversed.

DISCUSSION:

A) What specific anxieties were experienced by the "blind" partner?

B) Were the nonvisual aspects of the environment experienced differently?

C) What were some of the nonverbal cues used by the "sighted" partner to guide the "blind" partner?

D) As time passed, did the "blind" partner's degree of comfort increase or decrease?

TIME: 20-25 minutes

EXERCISE #4

AUDITORY SENSORY

DEPRIVATION

OBJECTIVE:

To allow participants to experience hearing loss

METHOD:

Materials needed: Ear Plugs

Facilitator selects volunteers to become "deaf" using ear plugs. Volunteers's ears are plugged and facilitator leads group discussion for 10-15 minutes. Volunteers are asked to share their experiences.

DISCUSSION:

A. How much of the discussion were volunteers able to understand?

B. Did "hearing" participants help "deaf" volunteers to understand what was being discussed?

C. What did volunteers notice about other "deaf" volunteers?

D. What were some of the feelings of "deaf" volunteers during the discussion?.....isolation?.....the feeling that they were the subject of discussion?

E. Did the volunteers at any point give up trying to understand the discussion?

TIME: 20-25 minutes

*** NOTE TO TRAINER**

To emphasize the impact of hearing loss on the cognitive abilities of older people, the facilitator may wish to have the volunteer try to explain to the group what was discussed.

HANDOUT #2

SENSORY CHANGES WITH AGING

I. **Vision**

A. 7% of persons aged 65-75 have blindness or other serious visual impairment

B. 65% of persons aged 75+ have visual impairments

C. Visual Disorders result in poor mobility, poor spatial orientation and sometimes frightening visual hallucinations

II. **Hearing**

A. Hearing loss affects more people than any other chronic condition, with older people being most affected:

13% of persons aged 65-75 are hearing impaired

26% of persons aged 75+ are hearing impaired

55% of all hearing impaired are aged 65+

B. Hearing loss may be of two types:

conductive - sounds are less loud

sensorineural - sounds are perceived unevenly

C. Hearing aids may or may not be helpful and may be frustrating to use.

III. **Touch**

A. Decreased touch sensations

B. Difficulty in manipulating objects

C. Decreased response to touch from others

D. Causes of reduced sensations include:

  Tremors caused by Parkinson's Disease

  Cerebrovascular Accidents (CVAs or strokes) which may go unnoticed

  Edema (swelling of hands and feet)

  Arthritis

  B 12 deficiency

  Diabetes Mellitus

IV. **Taste and Smell**

A. Number of taste buds declines (up to 50%)

B. Sweet and salty flavor identification disappears first, sour and bitter continue

C. 40% of people have trouble identifying things by smell by age 80

D. Since taste is related to smell, appetite may decrease

E. Women retain the ability to identify substances by smell longer than men

F. Obese people are better able to identify by taste

HANDOUT #3

GUIDELINES FOR ASSISTING THE OLDER PERSON WITH VISION LOSS

Always introduce yourself. Let the visually impaired person know to whom he is talking so he doesn't have to figure out who you are while trying to listen.

When you leave a visually impaired person, tell him that you are going.

Don't worry about using such words as "look" and "see" when you are talking to someone who is blind.

Speak directly to the person. If he is with a friend, do not use his companion as an interpreter.

Unless he is deaf, there is no need to speak more loudly to the person than you would to others.

Do not pet a guide dog or otherwise distract him from his job.

Use the same common sense and sensitivity toward the elderly blind person that you would with anyone else.

Certain things have to be explained. For example, a nurse who is about to give an injection should tell the patient so that he is aware of what will happen to him.

When teaching a blind person, explain the procedures fully and, wherever you can, let the sense of touch replace the sense of sight.

Allow the blind person the time he needs to learn a new skill. If the skill is complicated, break it down into steps and teach one step at a time.

Remember that the person who is older may not have a good memory.

Refer to the numbering on a clock when telling a blind person where things are placed in front of him. This is especially useful for placement of food at mealtime. For example, certain foods are always placed a 6 o'clock and milk is always above the plate at about 10 o'clock.

The American Foundation for the Blind (1972) recommends the following essentials in teaching skills for daily living:

Orientation to position and relationship to significant objects in the environment to maximize utilization of the remaining senses

Establishing mobility aptitude and patterns

Teaching the use of tailing-the art of using the backs of fingers to follow lightly over surfaces to determine location, find objects and determine the line of travel.

Handout #4

SIMPLE COURTESIES FOR THE HARD OF HEARING

Speech should be paced slowly enough to clearly enunciate syllables and give the person time to comprehend.

Keep your voice at about the same volume throughout each sentence; do not drop the voice at the end of the sentence. A lower voice range is often easier to hear.

Always speak as clearly as possible. Distinctness does not mean shouting.

Make the change to a new subject, a new name, a number, or unusual word at a slower rate.

Watch the expression on the listener's face and note when your words are not caught. Do not repeat the whole sentence. Usually one word or name was not clear.

Remember that the hard of hearing may depend to a considerable extent on reading your lips. Face them so they can see your lips as you speak.

Don't speak to hard of hearing persons abruptly. Attract their attention first by facing them and looking straight into their eyes, or by touching their hands or shoulders lightly.

Use a stethoscope and speak into the mouthpiece.

If persons have one good ear, stand or sit on that side when talking. Be sure their hearing aid is in place and turned on, and check to see that the batteries are working. Every gerontological nurse should know how to change a hearing aid battery.

Facial expressions are important clues to meaning. Remember that an affectionate or amused tone of voice may be lost on a hard of hearing person.

Many hard of hearing persons are unduly sensitive about their handicap and will pretend to understand you when they don't. When you detect this situation, tactfully repeat your meaning in different words until it gets across.

When you are in a group that includes a hard of hearing person, try to carry on your conversation with others in such a way that he can watch your lips. Let him know what is being discussed. NEVER take advantage of his handicap by carrying on a private conversation in his presence in low tones he cannot hear.

Use synonyms. Words with sibilant sounds (sh and s sounds in words such as fish and juice) are harder for older people to understand (NAHSA,1977).

Adapted from Nursing and The Aged, Irene Mortenson Burnside, 1981.

SEXUALITY

Background Information:

Sexuality encompasses many aspects of our personality. It is expressed as love, warmth, sharing, touching between people, and not simply the act of intercourse. Sexuality exists throughout life, in one form or another, in all persons. Older persons, whether they remain healthy and active or are frail, have a need to express sexual feelings. One way of expressing sexuality is through touching. Old people, especially older men, may find it difficult to reach out to others for stroking. Often, their previous lifestyles have cautioned against this, except in the intimate context of intercourse which may no longer be available. Older women, on the other hand, are given more freedom to touch, but often lack the opportunity. Many studies indicate that elderly people receive far less expressive touch than other age groups and therefore experience more touch deprivation.

At the same time, care givers, in the course of their daily responsibilities do intrude upon the most intimate areas of touch (face, neck, front of body, genitalia of their patients). Care givers are faced daily with the opportunities to provide touch in a condescending or uncaring way, or to provide gentle, reassuring, and renewing touch.

The use of touch involves risk, and may be misinterpreted by the nurse and/or patient. The intimacy of the care giver/patient contacts may influence the nurse to be overly cautious. Stirring sexual feelings, if that is a response to gentle touching, is a human response that need not be frightening. Old men and women who miss the touching and holding of their earlier lives, may seek this comfort with sexually provocative behaviors. While care givers should not encourage such overt behavior, they should understand the underlying need for intimacy and perhaps explore ways to meet those needs that are comfortable and appropriate for both the care giver and the resident.

As is the case with all other changes associated with the process of aging, there is much misinformation surrounding the sexuality of older people.Included among some of the more common myths are:

They do not have sexual desires;

They are physically incapable of sexual relations;

They are too fragile to have sexual relations;

They are unattractive to other persons; and

The idea of sex is shameful and perverse to most older people.

Interestingly, many people who have grown older believing in these myths and stereotypes may have additional fears about their own sexuality as older adults. These fears may include:

Fear of heart attacks and strokes as a result of sexual activity;

Fear that sex shortens life;

Fear of criticism for sexual behavior and attitudes; and

Fear of cultural stigmas and taboos

There are, of course, many legitimate explanations for a decline in sexual activity among older people, such as embarrassment about one's aged body or a fear of failure. A decline in sexual activity can also be related to such social and cultural factors as living arrangements and availability of partners. For many women, the greatest barrier is the lack of appropriate partners.

Contrary to popular myth, menopause does not necessarily cause a decrease in womens' ability to engage in sexual activity. In fact the desire for sexual involvement may increase, as the fear of pregnancy is reduced. However, such physical changes as atrophy of the vaginal wall, dryness, decrease in natural lubrication that do occur in post-menopausal women can be the cause of discomfort and subsequent decreased sexual activity.

While there is no exact physical equivalent to menopause among older men, physiological changes as the result of the aging process may lead to problems related to the ability to perform sexually. The fear of losing one's ability to function physically, and thus sexually, is a very common psychological phenomenon among older men.

EXERCISE #5

SEXUALITY IN THE LONG-TERM CARE SETTING

OBJECTIVE:

To provide an opportunity for participants to share experiences/concerns that they may have around issues of sexuality and care giving.

Many care givers, especially young women or less experienced females, experience a great deal of emotional stress associated with not knowing how to respond to expressions of sexuality by the residents for whom they care. For many, this exercise may offer a rare opportunity to discuss this issue in a supportive environment. As discussion of the case proceeds, participants should be encouraged to share their experiences.

METHOD:

Case Study

Mr. C. has been a resident of a long term care facility for two years. Four years ago, he had a stroke which has left him partially paralyzed on his left side. His wife of forty-five years cared for him at home until her death two years ago. Mr. C. has two children and several grandchildren but sees them infrequently as they live out of state.

Mr. C. needs considerable help with his ADL's, including bathing. For the past several weeks, during his bath, he has reached out to a particular young aide, trying to draw her close to him to kiss her. Ms. A. is confused and frightened. She likes Mr. C. a great deal and wants to continue to care for him. She is growing increasingly uncomfortable with his physical advances.

If you had an opportunity to advise Ms. A., what would you tell her?

DISCUSSION:

Several points for consideration should be mentioned by the participants and/or trainer:

1. Consider the circumstances during which the behavior occurs;
2. What are the precipitating events?
3. Assess for sensory deprivation
4. Recognize the needs involved - both the care giver's and the patient's
5. What is healthy about the situation?
6. Examine your own verbal/nonverbal reaction for possible misinterpretation
7. Do not punish
8. Help to find an appropriate way for the needs to be met

Time: 15-20 minutes

EXERCISE #6

ATTITUDES ON

SEXUALITY AND AGING

OBJECTIVE:

To explore participant's feelings about sexuality in aging.

METHOD:

Case Study

A residential staff member enters a semi-private room and finds two female residents cuddled together in the same bed. The staff person tells the occupants that kind of thing "isn't allowed here," and in a punitive voice orders one resident back to her own bed.

DISCUSSION:

1. What assumptions did the staff person make in this situation?
2. How did these assumptions relate to the staff person's attitudes toward sexuality?
3. Are sex and sexuality the same thing?
4. What would have been an alternative interpretation of the residents' behavior?
5. What does the alternative interpretation indicate about the needs of the two residents?

TIME: 15-20 minutes

HANDOUT #5

MINNIE REMEMBERS

God,
My hands are old.
I've never said that out loud before,
but they are.
I was so proud of them once.
They were soft
like the velvet smoothness of a firm
ripe peach.
Now the softness is like worn-out
sheets or withered leaves.
When did these slender, graceful hands
become gnarled and shrunken?
When, God?
They lie here in my lap,
naked reminders of the rest of this
old body
that has served me too well.

How long has it been since someone
touched me?
Twenty years?
Twenty years I've been a widow.
Respected.
Smiled at.
But never touched.
Never held close to another body.
Never held so close and warm that
loneliness was blotted out.
I remember how my mother used to
hold me, God.
When I was hurt in spirit or flesh
she would gather me close.
stroke my silky hair and caress
my back with her warm hands.
Oh, God, I'm so lonely!

I remember the first boy who ever
kissed me.
We were both so new at that.
The taste of young lips and popcorn.
The feeling deep inside of mysteries
to come.
I remember Hank and the babies.
How can I remember them but together?
Out of the fumbling, awkward attempt
of new lovers came the babies.
And as they grew, so did our love.

And, God, Hank didn't seem to care
if my body thickened and
faded a little.
He still loved it.
and touched it.
And we didn't mind if we were no
longer beautiful.
And the children hugged me a lot.
Oh, God, I'm so lonely!
Why didn't we raise the kids to be
silly and affectionate
as well as dignified and proper?
You see, they do their duty.
They drive up in their fine cars.
They chatter brilliantly and reminisce.
But they don't touch me.

They call me "Mom" or "Mother" or
"Grandma."
Never Minnie
My mother called me Minnie.
And my friends.
Hank called me Minnie, too.
But they're all gone.
And so is Minnie.
Only Grandma is here.
And, God! She's lonely!

Donna Swanson

COGNITIVE CHANGES

Background Information:

Much of the misinformation about the mental abilities of older people can be traced to early "scientific" research which concluded that intelligence declines with age. Today intelligence can be measured more accurately and we better understand the aging process. As a result, we now know that intelligence doesn't normally decline with age, but that with good health and activity, some abilities like judgement, accuracy and general knowledge, actually increase with age.

Although the weight of the average human brain decreases in later years, as the result of cell loss, a person's cognitive abilities may remain intact well into the individual's 80s, 90s and beyond. Recent research has shown that even in old age the cells of the brain continue to respond to an enriched environment by forging new connections to other cells. Intelligence depends not on age but on the stimulation and challenge that is available in the environment.

The time that it takes for the brain to respond to stimuli tends to slow down in later years, although generally doesn't affect the amount of information that an older person can process, or the accuracy at which it can be processed. While it may take a little longer for an older person to learn something new, in a healthy person the capacity and the desire to learn may never end.

The Myth of Senility

Senility, once thought to be caused primarily by hardening of the arteries, was once considered to be a certainty in old age. Today we know that the loss of mental abilities is never normal.

Senility isn't a natural condition of aging, in fact, "senility" isn't even a legitimate medical diagnosis, but a word used by some professionals and the public to describe problems such as confusion, forgetfulness and disorientation when they occur in older people. Even though they can occur at any time in life, because they are more common with advanced age, these problems are often mistakenly thought of as being age-related instead of illness-related.

Problems like memory loss, confusion and disorientation, particularly in later years, are often symptoms of physical health problems like heart, lung, and kidney disease. Vitamin deficiencies, malnourishment, and even reactions to alcohol and medications can also produce impairments in intellectual functioning. For the most part, these problems can be successfully treated and their effects on mental abilities reversed, allowing a return to a normal level of functioning. There are, however, some conditions which affect mental functioning, more common in later years, that cannot be reversed.

Strokes, caused by a restricted flow of blood to the brain are particularly common among older people. Even though strokes destroy brain cells, their effects vary greatly among individuals. For example, some stroke victims suffer major losses in brain functioning while others have only minimal problems and may never realize that they have had one or several small strokes. Although there is no cure for strokes, their effects on mental functioning can be minimized through rehabilitation and medications and prevention of strokes can be enhanced by controlling high blood pressure and diet.

In addition to stokes and physical illness which can affect mental functioning, some brain diseases are more common in later years. Alzheimer's disease is perhaps the most widely known of all brain illnesses yet the least understood. The actual cause of Alzheimer's disease is not yet known, nor do any cures presently exist. Each year millions of dollars are spent on research in an attempt to unlock the mystery.

Alzheimer's disease and other brain illnesses affect 7% of all persons aged 65 and older and are the fourth leading cause of death among that population, but they are also the most frequently misdiagnosed conditions which affect mental functioning among older people. The symptoms of these brain illnesses are not unique to those illnesses and may be found in a wide range of physical and mental health problems. For this reason, a great number of older people who could be helped are labeled as being senile or as having an incurable brain illness and lose, unnecessarily, the opportunity to lead a full and productive life.

HANDOUT #6

CHANGES IN THE NERVOUS SYSTEM AND COGNITIVE FUNCTIONING

A. Progressive loss of neurons (nerve cells) throughout life and decreases in brain weight

B. Poor circulation speeds up cell loss, especially in the brain

C. Personality changes can occur with advancing age:

   1. They are not necessarily the result of pathological brain dysfunction

   2. May result from environmental stress, organic changes or a combination of these

   3. May be positive, as people learn to put things in perspective more readily

D. Cognitive changes do occur, but are not a reflection of declining intelligence

   1. Thinking processes are slowed, but are usually intact

   2. Learning new motor skills becomes more difficult, and may take longer

   3. There is a reduction in the speed of learning not the capacity for learning

   4. Crystallized intelligence (store of past knowledge) does not decline while fluid intelligence (ease of new learning) may decline

   5. Intellectual changes may be the result of changes other than age:

      a. apparent failure to learn may be due to an attempt to solve new problems based on past experiences

      b. difficulty with hearing may cause difficulty with understanding speech, and is not the same as inability to learn

      c. lack of stimulation can slow learning process (at any age)

SECTION #C

PSYCHOLOGICAL

CHANGES AND NEEDS

CONTENT:

Background Information - Psychological changes and Needs..pg 40
Group Discussion - Aging and Self-Esteem ....pp 42-44
Exercise #1 - Case Study "Bill and Mr. Scott" ....pg 45
Handout #1 - Self-confidence ....pg 46
Handout #2 - Self-esteem ....pg 47
Exercise #2 - "What Do You See Nurse?" ....pg 48
Handout #3 - "What Do You See Nurse?" ....pg 49

SECTION C

PSYCHOLOGICAL

CHANGES AND NEEDS

Background Information:

One of the primary concerns among care givers in boarding and nursing care facilities are the behavioral problems exhibited by many older residents. In working with the older resident, particularly the resident with mental health problems, it becomes natural to attribute behaviors to individuals' psychosis or paranoia. Complicated explanations, sophisticated interventions, and treatment hold a mysterious fascination for many providers. However, many behavioral problems can be attributed to causes far more basic than imagined.

It is important for care givers to understand the basic psychological needs that are at risk in a long-term care setting, and to understand what they can do to help individuals to minimize the loss of self-worth, self-esteem and self-confidence.

Group Discussion

AGING AND

SELF-ESTEEM

OBJECTIVE:

To sensitize participants' to individuals' needs for self-esteem and self-worth, and to emphasize how those needs may be at risk in the nursing and boarding care setting.

METHOD:

The trainer may introduce this section by asking the following question: "What characteristics do you like to see in your residents here?" (Response to this question might include: ability to adjust to routine; willingness to enter into social activities, to form friendships, etc.)

Have you ever tried to make one of your mother's favorite recipes, only to ruin it by leaving out some key ingredient? I do best with the kind of recipe where everything is optional. Unfortunately, there are not many like that. A good recipe is simply a disaster if the right ingredients in their proper amounts are not used. In a similar way human beings, in order to make adjustments, socialize and form friendships, must possess certain ingredients which are not "optional". In fact, life is only existence without them. Let's consider just a few: Self-esteem, Self-confidence, and Dignity (Trainer might ask audience to define each of the psychological needs, then give examples to establish their importance).

Examples:

A. Someone with no self-confidence, in all probability could not hold down a job or maintain a relationship.

B. A young woman with no self-worth might well find a partner that could validate the low opinion she has of herself. Low self esteem is a prominent trait of abused wives.

C. Take away a person's dignity and he is devalued in his own eyes and the eyes of society.

I'm sure that we can all appreciate how extremely critical these elements are to life. They are important because they contribute to the most valuable possession we have, namely, our identity. A person's identity is that which sets him apart from others. It is our individual uniqueness, the sum total of who we are.

Question:

Self-esteem, self-confidence and dignity. Where do we get them? Are we born with them?

The trainer should initiate a discussion about the development of these psychological needs. Let the audience establish the following points:

1. We are not born innately endowed with these qualities.
2. They are developed in us by family, friends, teachers, and life experiences. In short, we are, to a large extent, the product of our environment.

Question:

Is there a specific stage in life when self-esteem, self confidence, and dignity are more important to us?

(Trainer should discuss the different points of view, which should establish the following conclusion: These needs are equally critical to each stage of our lives from birth to death. Each stage builds on the preceding stage).

Question:

While our need for a strong identity is constant throughout our lives, what kind of changes occur in old age that make self esteem, self-confidence, and dignity stand out in alarming importance?

(The trainer should initiate a discussion exploring the physical, mental and social losses which can threaten one's identity as he grows older. These might include - loss of spouse, home, independence, friends, health, etc.)

Remember that every physical, mental, and social change is a blow to the identity. The greater the change, the more devastating the blow.

Care givers who work with elderly people should make efforts to know as much of their history as possible. Our attitudes are profoundly affected when we can see those that we care for as having a childhood, being teenagers, falling in love, and having borne responsibility and made valuable contributions.

What does this have to do with behavior? Just as one fights for that last breath when life is ebbing away, people will fight to preserve their identity when it is threatened. Remember, there are more ways to die than just by physical death.

Question:

What kinds of behaviors might we see that are really reactions to a threatened identity?

(Responses to this question might include anger, withdrawal, combativeness and depression, to mention just a few. The trainer should point out the similarities to behaviors encountered in residents with various types of mental disorders)

It should therefore become a matter of course when addressing difficult behavior to study the physical environment and elements of care which might negatively affect the self-esteem.

Question:

How can we help develop self-esteem and self-confidence in our residents?

(The trainer should discuss the material on **Handouts #1 and #2**).

Because our schedules are often so busy it is easy to see how care givers can fall into routines or patterns of dealing with residents which, even though unintentional, might threaten their self-esteem.

TIME: 20-25 minutes

NOTE TO TRAINER: Suggested exercise to follow this discussion:
Exercise #1 - Case Study - Bill and Mr. Scott

Exercise #1

CASE STUDY

"BILL AND MR. SCOTT"

OBJECTIVE:

To help facility personnel to consider how residents self-esteem and dignity are at risk as the result of the day to day routine.

METHOD:

Participants are asked to read and discuss the following case study.

> Bill, a worker in a large boarding home, opens the door and walks into Mr. Scott's room. Mr. Scott is an elderly resident who has been keeping more and more to himself. He is up in a chair working at buttoning up his shirt.

Bill- (Walks in and begins to make up the bed) "Better hurry up gramps. We'll be late for breakfast."

Mr. Scott - "I'm not very hungry today."

Bill - "You'll feel better after you get something to eat."

Alice - (another worker on the floor walks in.) "Hi Bill. How is our friend here doing?"

Bill - "Getting there I guess. How was your weekend?"

Alice - "Had a great time. Can I give you a hand?"

Bill - (taking over the last two buttons) "No, I got it, thanks. There we are. Let's go get some breakfast."

DISCUSSION:

The following are points suggested for consideration:

1. The importance of a person's name. Should we nickname residents?
2. Is it important to knock or ask permission to enter a room, even in a institution?
3. Talking about the resident while in his/her presence?
4. Not really listening to resident.
5. Not allowing the resident to speak for himself.
6. Not allowing the resident to finish his/her task.
7. Infantilization ("Let us go," "Here we go" "How are we today")

TIME: 15-20 minutes

Handout #1

Self-confidence

What these needs are	Your residents need to feel self-confident about themselves and their abilities. They need to accept themselves and others as they are and to look at life objectively. They should function as independently as possible. Self-confident people establish satisfying relationships with people close to them and feel concern for the welfare of all.
What you can do	Help and allow residents to rely on and have confidence in themselves. Accept each resident's uniqueness. Assist residents to achieve and maintain highest level of independence possible. Encourage your residents to try something new, rather than sticking to secure and safe ways. Be willing to allow your residents to assume responsibilities.

Adapted from Abraham Maslow's Hierarchy of Human Needs

Handout #22

Self-esteem

What these needs are	Self-esteem means having a good image of oneself. Residents develop this sense of self-worth in several ways - through positive relationships with other, successful life experiences, and recognition of themselves as valuable.
What you can do	Never miss an opportunity to praise a resident for constructive contributions, thoughts or attitudes. Tell and show residents in specific ways why and how you find them valuable. Encourage residents to share their feelings and support them with care and affection.

Adapted form Abraham Maslow's Hierarchy of Human Needs

Exercise #2

"WHAT DO YOU SEE NURSE?"

OBJECTIVE:

To remind participants of their common bonds with patients and to renew empathy for those in their care.

METHOD:

12 minute videotape

"What Do You See Nurse?" is a poem found among the belongings of an elderly woman shortly after her death. It is about the experiences of one aged woman. The verses place the writer's moments in an institution within the context of her whole life, pleading that she be perceived as the person born of that whole context, and not just as a dependent patient.

DISCUSSION:

Discussion of the poem may lead to renewed realization that each LTC resident has had a life prior to entering the facility, that they once had hopes and dreams. They had a childhood and an adulthood. They were not always old and ill.

The poem is included in handout #3

*** Note to Trainer:**

"What Do You See Nurse?" is also a videotape produced by Emory University Hospital, Atlanta, GA in cooperation with Smith, Kline, and French Laboratories.

The videotape is available through:

Centron Films
1621 W. 9th
Box 687
Lawrence, Kansas 66044

Handout #3

"WHAT DO YOU SEE NURSE?"

What do you see nurse. What do you see.
Are you thinking when you are looking at me?
A crabby old woman, not very wise,
Uncertain of habit, with faraway eyes,
Who dribbles her food and makes no reply.
When you say in a loud voice, "I do wish you'd try"
Who seems not to notice, the things that you do,
And forever is losing, a stocking or shoe
Who unresisting or not lets you do as you will,
When bathing and feeding, the long day to fill.
Is that what you're thinking, is that what you see?
THEN OPEN YOUR EYES, NURSE, YOU ARE NOT LOOKING AT ME.

I'll tell you who I am, as I sit here so still.
As I rise at your bidding, as I eat at your will.
I'm a small child of ten with a father and mother,
Brothers and sisters, who live with one another.
A young girl of sixteen, with wings on her feet.
Dreaming that soon now a lover she'll meet.
A bride soon at twenty, my heart gives a leap
Remembering the vows that I promised to keep.
At twenty-five now, I have young of my own.
Who need me to build a secure happy home.
A woman of thirty, my young now grow fast.
Bound to each other, with ties that should last.
At forty my young sons now grow and will be all gone.
But my man stays behind me to see, I don't mourn.
At fifty, once more babies play round my knee,
Again we know children, my loved one and me.

Dark days are upon me, my husband is dead.
I look at the future I shudder with dread.
For my young are all busy, rearing young of their own.
And I think of the years, and the love that I've known.
I'm an old woman now, and nature is cruel.
It's her jest to make old age look like a fool.
The body it crumbles, grace and vigour depart.
There is now a stone, where I once had a heart.
But inside this old carcass, a young girl still dwells,
And now and again, my battered heart swells.
I remember the joys, I remember the pain,
And I'm loving and living life all over again.
I think of the years, all too few-gone too fast,
And accept the stark fact, that nothing can last.
So open your eyes, nurses, open and see,
Not a crabby old woman. Look closer - see ME

UNIT #1

AGING PROCESS

OVERVIEW

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UNIT #1

AGING PROCESS

OVERVIEW

Detailed outline of Exercises

OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION A:			
1. Participants will share with each other and presenters information about themselves and their perceptions of aging.	Exercise #1 Ground Breaking	Group Discussion/ Introductions	15-20 minutes
2. Participants will explore and share early experiences with older people, and how those experiences shape present day perceptions.	Exercise #2 Guided Reminiscence	Visualization Activity/ Group Discussion	25-30 minutes
3. Participants will explore and share their perceptions of their own aging.	Exercise #3 Guided Meditation	Visualization Activity/ Group Discussion	25-30 minutes
4. Participants will test their knowledge of issues in aging and explore the sources of prevalent myths.	Exercise #4 Myths and Facts Questionnaire	True/False Quiz/ Group Discussion	25-30 minutes
SECTION B:			
1. Participants will identify and discuss physical changes that occur during the process of aging.	Exercise #1 Inventory of Physical Change	"Brainstorming"/ Group Discussion	20-25 minutes
	Exercise #2 Mobility Impairment	Activity/ Group Discussion	20-25 minutes

UNIT #1

AGING PROCESS

OVERVIEW

Detailed outline of Exercises

OBJECTIVE	ACTIVITY	METHOD	TIME
2. Participants will discuss sensory changes related to aging, especially as they relate to emotional health	Exercise #3 Visual Sensory Deprivation	Group Activity and discussion	20-25 minutes
	Exercise #4 Auditory Sensory Deprivation		20-25 minutes
3. Participants will discuss sexuality and aging	Review Background Information	Group Discussion	
4. Participants will examine their own attitudes about sexuality and aging	Exercise #5 Sexuality in the Long-Term Care Setting	Group Problem Solving	15-20 minutes
	Exercise #6 Attitudes on Sexuality and Aging	Group Discussion	15-20 minutes
5. Participants will review cognitive changes related to aging	Handout #5 Changes in the Nervous System and Cognitive Functioning	Mini-lecture and handout	15 minutes

UNIT #1

AGING PROCESS

OVERVIEW

Detailed outline of Exercises

OBJECTIVE	ACTIVITY	METHOD	TIME
Section C			
1. Participants will review three major psychological needs of aging persons	Background Information: Handout #1 Self-confidence Handout #2 Self-esteem Discussion Aging and Self-esteem	Mini-lecture Group Discussion	20-25 minutes
2. Participants will discuss ways that they may enhance residents sense of identity, self-esteem, and confidence	Exercise #1 "Bill and Mr. Scott"	Group Activity	15-20 minutes
	Exercise #2 Video "What Do You See Nurse?"	Video	15 minutes

GERIATRIC EDUCATION

&

RESOURCE OUTREACH

UNIT #2

LOSS

Unit #2

LOSS

Unit #2 addresses the significance of loss in the lives of elderly residents of boarding and nursing care facilities. Though loss occurs to individuals at every age, the frequency and magnitude of losses experienced by residents of long term care facilities can profoundly influence the quality of their daily lives.

Section A considers the nature of change and loss in our lives. Participants have the opportunity to experience their own reaction to loss and to consider the meaning of loss to the elderly people for whom they care. Section B focuses on the grief process itself, examining the stages of mourning and the importance of recognizing, acknowledging, and supporting the grief process. Section C helps the caregiver to explore his or her feelings and attitudes toward death. In so doing, they might recognize and address the support needs of their clients more effectively as they face their own death, the death of a loved one or the death of a fellow resident.

The content of this unit can evoke strong emotions. The topics addressed (loss, grief and death) are ones that few are entirely comfortable with. Yet, they are issues that caregivers must face daily in the long term care setting. Included in the unit are interventions that caregivers can use to help residents cope with and adjust to loss. Moreover, as a result of participating in this unit, caregivers can learn to protect their residents from incurring unnecessary losses.

OBJECTIVES:

Section A	To sensitize participants to the emotions associated with loss.
	To discuss the special significance of loss as it relates to elderly boarding and nursing home residents.
	To identify physical and behavioral changes that may accompany multiple and overlapping losses.
Section B	To discuss the grieving process as it relates to loss and death.
	To examine personal attitudes about death and the coping skill used in dealing with loss.
	To discuss interventions that will help residents cope with the death of a friend, family member, or resident of the home.

SECTION C To review the stages of the process of death and dying.

To discuss death from the perspective of being the final stage of the normal life process.

To discuss the range of feelings experienced by terminally ill people.

CONTENT:

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SECTION A

CHANGE AND LOSS

CONTENT:

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Exercise #2 - Change and Loss ....pp. 5-6

Exercise #3 - The Experience of Loss Worksheet ....pp. 7-8

Exercise #4 - "Compassion....I Suppose" ....pg. 9

Exercise #5 - Losses and Feelings Experienced by Residents.. pp. 10-11

Exercise #6 - Loss and the Elderly Reaction Sheet ....pp. 12-16

CHANGE AND LOSS

Background Information:

Change and loss are part of every person's life from the moment of birth. Even as infants, with every stride toward independence, we lose the security of having all of our needs met by others. During most of our lives, however, losses are counter-balanced by gains until old age when losses usually outnumber gains. Loss has been described as a concept synonymous with aging. Losses have a cumulative effect that is felt acutely in old age.

Each loss sustained, results in a change that must be adjusted to. Change is one cause of stress in our lives. Too many changes in too short a time can inhibit one's ability to cope and adapt. Response to loss and change can influence one's physical health as well as mental and emotional well being. The profound and multiple losses of self esteem brought about by aging, illness and institutionalization are considered a major factor in the incidence of depression in elderly people living in long term care facilities.

Loss is a value-laden concept. We grieve the loss of something according to the value we place upon it. Because our values are different, we as caregivers cannot presume to understand the significance of a loss to an individual. We must use our listening and observational skills to understand the meaning of another's loss.

As caregivers, we also realize that each person brings a unique array of strengths and resources, both internal and external, with which to cope with change and loss. We are in the unique position to assist residents to use their coping abilities in adjusting to the losses that they experience. We also have the opportunity to prevent unnecessary losses to self-esteem. Our charge is to nurture and to sustain even the most fragile of egos of the elders for whom we care so they might enjoy the highest quality of life possible.

EXERCISE #1

THE EMOTIONAL IMPACT OF LOSS

OBJECTIVE:

This exercise is intended to help sensitize the participant to some of the stress associated with multiple losses.

METHOD:

Each participant lists on paper the ten things that they feel are most important to them in their lives. They do not need to be listed in order of importance and they do not need to be material possessions. The list may include people, pets, talents, and personality characteristics, etc. Participants should be assured that they will not be asked to share what is on their list unless they wish to do so.

Narration:

WITH YOUR COMPLETED LIST, REVIEW IT CAREFULLY AND CROSS OFF ONE OF THE ITEMS. YOU WILL NO LONGER HAVE THIS ONE THING AS PART OF YOUR LIFE.

(pause)

NOW, REVIEW YOUR LIST AGAIN AND CROSS OFF TWO MORE ITEMS. YOU NO LONGER HAVE THESE AS PART OF YOUR LIFE.

(pause)

NOW CROSS OFF ONE MORE ITEM.

(pause)

YOU MAY WISH TO STOP AT THIS POINT BECAUSE YOU ARE FEELING UNCOMFORTABLE. YOU MAY NOT STOP. CROSS OFF TWO MORE ITEMS.

(Pause)

IF YOU HAVE BEEN HONEST WITH YOURSELF AND HAVE LISTED THOSE THINGS THAT YOU VALUE MOST, YOU MAY NOW HAVE GREAT DIFFICULTY IN DECIDING WHAT TO ELIMINATE NEXT. YOU MAY FEEL LIKE CHEATING OR WISH THAT YOU HAD NEVER STARTED THIS EXERCISE. NONETHELESS, CROSS OFF TWO MORE ITEMS.

TWO MORE ITEMS REMAIN ON YOUR LIST. WHICH ONE WILL YOU CROSS OFF? YOU MUST MAKE A CHOICE.

(pause)

THIS ITEM THAT YOU HAVE REMAINING IS THAT WHICH YOU VALUE MOST. (End of Narrative)

METHOD: **(Cont.)**

At this point there may be noticeable tension in the room. Encourage participants to share their feelings. Expect some negative reactions. Some may wish to share which thing they retained. While these participants should be given the opportunity, assure others who may not wish to share, that their feelings will be respected.

DISCUSSION:

This experience should be followed by a general discussion which includes the following points.

1. The experience of losing so much in such a short time is difficult and emotionally stressful.
2. In life we have little control over what we lose. We must cope with the losses as they occur. Often a sense of being "out of control" contributes to one's stress.
3. Many parts of our lives are intertwined. A loss in one part of our life may precipitate losses in other parts, i.e., loss of a driving license may result in loss of independence.
4. While those things that we value most may differ from one another, we can at least empathize with the feelings of those who have lost what they value most.
5. Care should be taken not to judge others' values as good or bad.

NOTE TO INSTRUCTOR:

Before proceeding to the next section, the trainer should lighten the mood a bit by "giving back" all that the participants lost.

It is essential that the trainer complete this exercise prior to using it as a tool as it can be an emotionally draining experience. The trainer can be more empathetic having completed the exercise.

TIME: 15 - 20 minutes

EXERCISE #2

CHANGE AND LOSS

OBJECTIVE:

This exercise assists the participant in understanding the relationship between change, loss and stress in their own life as well as the lives of the elderly persons for whom they care.

METHOD:

Each Participant completes the Holmes and Rahe **Life Change Scale** (attached). Group discussion follows.

DISCUSSION:

There is an increase in research that indicates the existence of a direct connection between the emotional response to stress and one's physical health. In other words, the mind/body connection is real and not imagined.

Individuals can live with varying amounts of stress. What might be stressful for one may be exciting for another. Like strings on a violin, each of us plays a beautiful note under a different level of tension.

The **Life Change Scale** measures only one type of life stressor - change. Stress can also come from other aspects of life such as our relationships, our attitudes, expectations and our environment. It is very difficult to separate these different factors and the effects that they have on us.

After these brief comments, and the sharing of comments by the group, the connection to loss and the elderly person is discussed. The trainer, assuming the role of a 62 year old female, recently widowed, completes the inventory. In considering the concurrent life style changes that would likely to have occurred as a result of this one major loss, the total life change score this woman experiences is in excess of 500 points.

Since most participants in the group do not usually score over 300 points, they are usually quite impressed by the number of stress points the widow experiences. Some general discussion might follow concerning the impact of change on the woman's mental and physical health.

NOTE TO INSTRUCTOR:

Though directions for completion of the Life Change Scale are on the handout, clarification may be needed. Participants are to consider changes that have occurred during the **last twelve months** only. For each event that has occurred, participants should place a check mark in the "happened" column.Then look across to the numerical value for that item and include it under "your score." Once completed, the total score is calculated. **TIME**: 15 Minutes

WHAT EVENTS HAVE HAPPENED TO YOU IN THE PAST 12 MONTHS?

SCORE YOURSELF ON THE LIFE CHANGE SCALE - TOTAL SCORE FOR 12 MONTHS ___

Event Rank	Event Value	Happened (v)	Your Score	Life Event
1	100	______	______	Death of a Spouse
2	73	______	______	Divorce
3	65	______	______	Marital Separation
4	63	______	______	Jail Term
5	63	______	______	Death of Close Family Member
6	53	______	______	Personal Injury or Illness
7	50	______	______	Marriage
8	47	______	______	Fired From Job
9	45	______	______	Marital Reconciliation
10	45	______	______	Retirement
11	44	______	______	Change in Health of Family Member
12	40	______	______	Pregnancy
13	39	______	______	Sex Difficulties
14	39	______	______	Gain of New Family Member
15	39	______	______	Business Readjustment
16	38	______	______	Change in Financial Status
17	37	______	______	Death of a Close Friend
18	36	______	______	Change to Different Line of Work
19	35	______	______	Change in Number of Arguments with Spouse
20	31	______	______	Mortgage over $10,000
21	30	______	______	Foreclosure of Mortgage or Loan
22	29	______	______	Change in Responsibilities at Work
23	29	______	______	Son or Daughter Leaving Home
24	29	______	______	Trouble With In-Laws
25	28	______	______	Outstanding Personal Achievement
26	26	______	______	Wife Begin or Stop Work
27	26	______	______	Begin or End School
28	25	______	______	Change in Living Conditions
29	24	______	______	Revision of Personal Habits
30	23	______	______	Trouble With Boss
31	20	______	______	Change in Work Hours or Conditions
32	20	______	______	Change in Residence
33	20	______	______	Change in Schools
34	19	______	______	Change in Recreation
35	19	______	______	Change in Church Activities
36	18	______	______	Change in Social Activities
37	17	______	______	Mortgage or Loan Less than $10,000
38	16	______	______	Change in Sleeping Habits
39	15	______	______	Change in Number of Family Get - Togethers
40	15	______	______	Change in Eating Habits
41	13	______	______	Vacation
42	12	______	______	Christmas
43	11	______	______	Minor Violations of the Law

Note: The more change you have, the more likely you are to get sick. Of those people with over 300 Life Change Units for the past year, almost 80% get sick in the near future; with 150 to 299 Life Change Units, about 50% get sick in the near future; and with less than 150 Life Change Units, only about 30% get sick in the near future.

EXERCISE #3

THE EXPERIENCE OF LOSS WORKSHEET

OBJECTIVE:

Participants have the opportunity to put themselves "in the shoes" of a resident for whom they care. They consider the kinds and extent of losses this person has sustained as well as the long-term effects of those losses. An opportunity for considering one's own values regarding loss is also provided.

METHOD:

A worksheet entitled **The Experience of Loss** (attached) is given to each participant prior to the workshop. They are asked to bring the completed worksheet to the training. At that time, responses are shared for group discussion.

DISCUSSION:

Emphasis should be placed on the diversity of responses with regard to feelings, coping skills, and the variety of things that people value.

Discussion about all of the losses one sustains when moving to a boarding or nursing home should also occur at this time. Sharing their thoughts about the particular resident they chose for completing the worksheet will enhance this discussion, as well as offer a new perspective on a long-term care resident.

TIME: 10 minutes

THE EXPERIENCE OF LOSS

Worksheet

In this exercise, we will discuss the experience of loss in our lives and in the lives of residents of the boarding/nursing home. Please take a few minutes to complete this worksheet and bring it with you to the training session on Loss.

GUIDELINES:

Find a comfortable spot and a quiet time to think. This exercise should not take more than a few minutes to complete. You may find it helpful to read the questions first, then close your eyes, take a few cleansing breaths, and begin.

Visualize one of the older residents that lives in the home where you work. Think of all that you know about this person and consider the following questions:

1. What do you have in your life that you may well have lost if you were this older resident (consider the physical, emotional and social losses that made it necessary for you to move to a boarding/nursing home)?

2. What did you have to give up when you entered the nursing/boarding home?

3. You can bring only three material possessions with you to your new home (besides your clothes, medications and toiletries). What would they be?

4. One of your possessions is missing shortly after your arrival at your new home. How do you feel?

EXERCISE #4

Videotape

"COMPASSION......I SUPPOSE"

OBJECTIVE:

To provide participants the opportunity to hear directly from nursing home residents their thoughts and feelings about the losses they have incurred as a result of moving into a long-term care facility.

METHOD:

Videotape, "Compassion.....I Suppose"

Contact: Ross Laboratories
625 Cleveland Avenue
Columbus, Ohio 43215

DISCUSSION:

This videotape highlights some of the feelings of loss that residents in a nursing home experience. The program was taped in a nursing home, using residents and their direct caregivers as the "actors and actresses." They present a picture of both the joys and heartaches of living and working in a long-term care facility.

The film provides a very moving, yet realistic, view of what the concept of loss can mean to the elder person living in this setting.

NOTE TO INSTRUCTOR:

This film is most appropriate in a nursing home setting, though some boarding homes may find it useful. It may be used in addition to, or as a replacement for exercise #6, the Loss and the Elderly Reaction Worksheet.

TIME: 25 minutes

EXERCISE #5

LOSSES AND FEELINGS EXPERIENCED BY RESIDENTS

OBJECTIVE:

To identify the losses that residents experience in long-term care facilities and to discuss the feelings that residents may experience as a result of those losses. In addition, the caregiver will identify feelings that they themselves experience while caring for residents.

METHOD:

This exercise may be completed individually or in small groups. Participants list the losses that residents may incur in a long-term care setting. They are encouraged to place a word that describes a feeling beside the loss to describe how they think the resident must feel. They are also encouraged to add a word that describes a feeling they experience when a resident reacts to a loss. A list of words which can be used may be handed out along with the worksheet.

Have participants share their lists and note the results on a flip chart.

NOTE TO INSTRUCTOR:

If any group has difficulty identifying losses, you may give a few examples to get them started, i.e., loss of spouse, body image, driver's license, sexual partner, home rituals, pets, social status.

TIME: Approximately 10 minutes, depending on the number of small groups

LOSSES AND FEELINGS EXPERIENCED BY RESIDENTS

Worksheet

LOSSES	RESIDENTS'S FEELINGS	STAFF FEELINGS

EXERCISE #6

LOSS AND THE ELDERLY

OBJECTIVE:

This exercise is intended to stimulate discussion among participants about aging and loss.

METHOD:

Each participant is given a copy of the Loss and the Elderly Reaction Worksheet (attached). They are asked to respond to each of the ten statements. Participants circle the number that most accurately reflects their feelings about the statement (1=strongly agree - 5=strongly disagree). After completing the worksheets individually, the trainer facilitates a group discussion by reviewing each individual statement and asking participants to share their reactions. This method is usually quite sufficient to stimulate a lively discussion.

DISCUSSION:

The statements are reviewed below with discussion comments. Usually the relevant information will come naturally from the discussion as a function of group sharing. If not, the trainer may comment.

NOTE TO INSTRUCTOR:

Completion of the Emotional Impact of Loss (exercise #1) and the Experience of Loss exercise (exercise #3) prior to completing this worksheet would enhance the objective of this exercise.

TIME: 30 - 45 minutes

LOSS AND THE ELDERLY

Worksheet

1. Loss of self-worth, loss of role and loss of significant others are three special losses of elderly persons

Strongly Agree — Strongly Disagree
1 2 3 4 5

2. It is safe to assume that a person leaving a less desirable living situation to move to a more desirable one will not experience many losses.

Strongly Agree — Strongly Disagree
1 2 3 4 5

3. What we grieve as loss is the truest indicator of our own values.

Strongly Agree — Strongly Disagree
1 2 3 4 5

4. You can pretty well gauge the importance of loss to an individual by comparing it to how you would feel if you experienced the same loss.

Strongly Agree — Strongly Disagree
1 2 3 4 5

5. Older people can cope better with loss than younger people.

Strongly Agree — Strongly Disagree
1 2 3 4 5

6. It is possible for care givers to decrease the number of unnecessary losses the resident experiences.

Strongly Agree — Strongly Disagree
1 2 3 4 5

7. Encouraging reminiscence can be useful in helping an individual come to terms with life changes.

Strongly Agree — Strongly Disagree
1 2 3 4 5

8. Holding on to belongings, people or objects is a way of holding onto the past and avoiding more loss.

Strongly Agree — Strongly Disagree
1 2 3 4 5

9. The behavior of persons reacting to multiple losses can look like symptoms of dementia.

Strongly Agree — Strongly Disagree
1 2 3 4 5

10. The way in which an aged person deals with loss may be the single most important factor influencing the quality of life in later years.

Strongly Agree — Strongly Disagree
1 2 3 4 5

LOSS AND THE ELDERLY

Trainer's Guide

1. **Loss of self-worth, loss of role, and loss of significant others are three special losses of the elderly.**

Response:

While people might suffer any of these losses at any time in life, the social reality of old age creates an environment where these losses are more likely to occur.

2. **It is safe to assume that a person leaving a less desirable living situation to move to a more desirable one will not experience many losses.**

Response:

While there may be many gains associated with moving to a more desirable environment, some of the losses a resident might experience when moving include (but are not limited to):

Loss of familiar territory

Loss of routine

Loss of friends and acquaintances

Loss of personal space

Loss of independence

3. **What we grieve as loss is the truest indicator of our values**

Response:

People are asked at this point to reflect on the Emotional Impact of Loss exercise and recall that not everyone kept the same items when they were forced to choose. They might also recall from that exercise that people chose a wide variety of items that they would want to bring with them to the boarding or nursing home should they move to such an environment. As the participants share their thoughts and feelings, the trainer should emphasize not just the differences in the items but the sameness of the feelings surrounding the choice of the articles as well (need for familiar, need to recall the past, need to feel useful and/or active, need for identity, etc.).

4. **You can pretty well gauge the importance of a loss to a person by comparing it to how you would feel if you experienced the same loss.**

Response:

Because we can never understand exactly what a loss means to a person (because we are not that person), it is important that we listen carefully to what the loss means to the resident. Active listening, eye contact, touch, and empathy are some of the therapeutic interventions that are helpful. Do not assume that you understand and do not judge whether or not a loss is worthy of being grieved.

5. Older people can cope better with loss than younger people

Response:

Older people have likely had more experience with loss, and may well have learned how to put losses in their proper perspective. On the other hand, because we endure multiple losses as we grow older, we may not have the resiliency to come back from those losses. Also, many in our support network may have died and we are left to cope on our own.

The reality is that we cannot group older people into one homogeneous group and predict that they will react in a certain way. Each person is an individual and will respond in his or her own style. If a person coped well with loss in the past, they will likely continue to do so in the future.

6. It is possible for caregivers to decrease the number of unnecessary losses the resident experiences

Response:

The caregiver can promote choice where ever possible, and can foster independence in daily activities. The caregiver may also create opportunities for the resident to give love, thereby enhancing self-esteem. The trainer should ask for concrete examples of interventions that a caregiver might implement to foster self-esteem.

7. Encouraging reminiscence can be useful in helping an individual to come to terms with life changes.

Response:

Sometimes the retelling of an experience can reduce the pain associated with it. It can also help people to recall previous coping tools, as well as reinforce the fact that they have survived difficult times before and can likely do so again. Sharing reminiscences can also increase self-esteem by affirming the contributions a person has made to the world (children, work, etc.). There is also, for many people, a need to tell. This work can be done quite nicely in group settings.

8. **Holding on to belongings, people or objects is a way of holding on to the past and avoiding more losses.**

Response:

This is especially true if other stressors are affecting the resident, if coping skills are weak, or if self-concept is poor. Loss of these objects or people can actually be perceived as a crisis.

9. **The behavior of persons reacting to multiple losses can look like symptoms of dementia.**

Response:

Participants should recall, for a moment, a previous personal experience with a crisis situation. Ask them to remember how they felt. Suggest the feelings of shock, denial, disorganization, confusion, indecisiveness, withdrawal, and depression. You will likely notice nods of assent. Remind participants that these feelings and behaviors are often regarded, inappropriately or not, as symptoms of dementia in the elderly. Depression causes a decrease in attention, concentration, changes in memory as well as feeling of sadness, etc. It is therefore possible for prolonged grief and depression to look like dementia.

10. **The way in which an aged person deals with loss may be the single most important factor influencing the quality of life in later years.**

Response:

Because losses are multiple and there are probably fewer people available to offer support, good coping mechanisms for dealing with loss would seem to be critically important for the older person's quality of life.

Section B

GRIEF

CONTENT:

Background Information ....pg. 18
Group Discussion - Tasks of Mourning ....pp. 19-21
Exercise #1 - Personal Grief History ....pp. 22-24
Handout #1 - Memorial Service ....pg. 25-26
Handout #2 - Stages of Grief ....pg. 27
Handout #3 - Interventions ....pg. 28

GRIEF

Background Information:

It is likely that most participants have either personally experienced an important loss or have known someone who has been devastated by such a loss. Almost anyone who has ever experienced loss has suffered its accompanying emotional distress. For some, unresolved grief may lead to prolonged episodes of serious depression.

This section will help participants gain a better understanding of the experiences that those for whom they care (as well as themselves) go through as the result of loss. Emphasis will be placed on 1) the stages of the grief process, and 2) the various ways in which caregivers may help residents to either ease or resolve their grief following a loss.

GROUP DISCUSSION

TASKS OF MOURNING

Those who work with elderly residents in boarding and nursing homes are constantly aware of the imminence of death. As caregivers, our own lives are often directly affected by the deaths of those residents for whom we care. We often grieve their deaths as a personal loss.

Think for just a moment of the residents in your care. Let your mind imagine the multitude of losses that they have experienced in their lives. For many, the world as they know it has become quite small. You and perhaps only a few fellow residents comprise most of the structure and the routine of their world and therefore the security within. Imagine now that death has invaded this world and taken one of the people from it.

Think of yourself for a moment as one of the surviving residents. Can you describe some of the things you might be feeling?

Note to the Instructor:

This is an excellent question for "loosening up" participants at the beginning of the session as it encourages participation and gives the group a feel for the subject matter.

Responses to the above question might include shock, numbness, anxiety about one's own mortality, depression, anger, and even physical symptoms (listlessness, constipation, weariness, etc.).

We can all appreciate how rapidly health would break down if this level of emotional pain were maintained over a long period of time. The grieving process has been compared by some to a serious wound where every system in the body is affected in some way. It is only with time that healing can occur and the person can function normally again. The process of mourning or grieving is one which results in emotional healing that enables one to carry on with his life.

We think of the grief process in terms of "tasks." Tasks simply imply that there are certain things that must be accomplished in order for "grief work" to be finished or resolved.

FIRST TASK - ACCEPTING THE REALITY OF THE LOSS

When someone dies, even when the death is expected, there is always a sense of disbelief, that it hasn't really happened. The first task of mourning is to accept the reality that the person is gone and will not return.

The instructor may discuss the various ways that people deny the reality of death, for example:

(a) **Mummification** - keeping clothing ready for use when the loved one returns, or keeping the room exactly the way it was;

(b) **Denying the significance of the loss** - "We were never really close" - "he wasn't a good father," etc.

(c) **Denying that the death is irreversible** - some even try to contact the loved one who has died through spiritualism.

Question:

If you have had a death in the home, how can you help the surviving residents accept the reality of the loss?

Discussions should stress the importance of:

(a) Allowing residents to attend funeral services when possible. This will help bring some closure to the relationship that the resident has had with the deceased.

(b) A simple memorial service in the home is a good way to give others the opportunity to say goodbye. Often it is more effective and meaningful if the staff conduct them (a format for a simple memorial service is suggested in handout #1 - pp. 25-26). Participation in a memorial service can also be a healthy way for staff to deal with the loss of a resident.

(c) It is often important for residents to be involved in final arrangements even if only in a small way, e.g., selecting cards, choosing flowers.

(d) Gravesite visit can be very helpful.

SECOND TASK - EXPERIENCING THE PAIN OF GRIEF

If "grief work" is to be completed, a person must go through the pain of grief.

Society is often uncomfortable with the feelings of the mourner. Subtle messages that the mourner does not have to hurt are evidenced in such phrases as "be brave," "buck up", and "don't cry." Remember, losses must be grieved. Continual avoidance, denial, or suppression of this pain will only serve to prolong the course of the mourning process. Caregivers are often particularly uncomfortable with this second task. After all, a caregiver's job is to alleviate pain. Staff may feel frustrated, and perhaps even guilty, because there is nothing that they can do or say to make the pain go away. It is important to understand that experiencing the pain of grief is a needful part of the healing process.

The instructor may want to discuss other methods people use to avoid pain such as travel, drugs, and/or alcohol, to mention a few.

In one class a participant related the following experience.

"I LOST MY FATHER WHEN I was seven years old. To spare me the pain I was told that he had just gone on a long trip and would return some day. After years of emotional problems I began therapy sessions. It was twenty-seven years after he died that I was finally able to come to terms with my father's death and grieve the loss."

A high price can be paid for dishonesty -especially with children. Caregivers (and families) often try to "protect" the elder from the death of a loved one. This is usually a mistake. The grief process is complicated when the lost person has a complicated or problematic relationship with the survivor. Talking about this helps. There is often grief for what might have been, and guilt for what was. Depression commonly occurs then.

THIRD TASK - ADJUSTING TO THE ENVIRONMENT IN WHICH THE DECEASED IS MISSING

The difficulty in this task depends, of course, on the individual's relationship to the deceased. This task should bring to mind that this process is not a thirty day or six month program but a long-term healing process. This adjustment may be particularly difficult for nursing and boarding home residents where support systems may already be significantly diminished. The instructor should emphasize the extra care and patience which is needed during this time.

FOURTH TASK - TO WITHDRAW EMOTIONAL ENERGY AND REINVEST IT INTO ANOTHER RELATIONSHIP, CAUSE, OR INTEREST

Again, the importance of consistent reassurance and encouragement towards involvement in life following a loss should be stressed by the instructor.

EXERCISE #1

PERSONAL GRIEF

HISTORY

OBJECTIVE:

In seeking to better understand the feelings of others, it becomes important to understand our own feelings. This exercise will help participants to examine their own attitudes about death and how they themselves have coped with personal losses.

METHOD:

The Personal Grief History worksheet (attached) is distributed a few days before the session. Participants are told that the forms are simply a tool to help them think through past experiences and that they will not be reviewed line by line in class. Having completed the form, they will be prepared to participate in the group discussions. Often the simple experience of losing a pet will enable one to see how the process has worked in their own or their children's lives.

Note to the Instructor:

Since this experience may evoke some painful feelings among participants, the instructor will want to make sure that participants feel comfortable to either share or not share with the group, as they may choose.

DISCUSSION:

The goal of this exercise is to help the group to observe the grief process in the experiences that are shared. Following are a few suggested questions to help in guiding the class.

(a) Feelings:	Do you remember how you were feeling when this happened?
(b) Coping:	How did you cope? What was most helpful during this time? What was most difficult?
(c) Grieving:	Looking back now, how did you know when the grieving was completed? What was the hardest task for you?

Time: 10 - 15 minutes

PERSONAL GRIEF

HISTORY

Worksheet

In order to be effective in working with those who suffer great losses we need to understand the process of mourning. What is it like to go through the experience of grief and to have the curative process of mourning take place. There is nothing like looking at a significant loss in one's own life to bring home the reality of the grief process. I hope you will take the time to work on this personal grief history and bring it with you to the training session on Loss.

1) **The first death I can remember was the death of..........**

2) **I was age ....**

3) **The feelings I remember having at that time were ....**

4) **The first funeral, wake or memorial service that I attended was.......**

5) **I was age ....**

6) **The thing that I remember most about the experience is ......**

7) **My most recent loss by death was ...person... Circumstances**

8) **I coped with this loss by ....**

9) **The most difficult death for me was....................**

10) **It was difficult because...............**

11) Of the important people in my life who are now living, the most difficult death for me would be the death of ....

12) It would be most difficult because.............

13) I know my own grief is resolved when ....

14) It is appropriate for me to share my own experiences of grief with a resident when......................

HANDOUT #1

MEMORIAL SERVICE

The following is a suggested format for a deceased resident's memorial service. The handout may be used in part or in its entirety to provide facility administrative and direct service staff with ideas for creating a service that will help to address the grief needs of surviving residents and staff alike.

For the purposes of a memorial service, extensive rearranging or decorating of the room to be used is not necessary and should be kept simple. A comfortable arrangement of chairs, perhaps a table with some flowers, and a picture or series of pictures of the deceased can provide an appropriate atmosphere for the service.

Welcome

"We want to welcome each of you to this memorial service to honor the memory of......... I know that.......would be pleased to see so many loved ones here today (A brief personal history of the deceased might be included here)."

Remarks

"The first purpose of our service is to give us an opportunity to remember....We are here because.....holds a special place in our affections and is most deserving of this recognition. I know of no higher honor that we can give than to keep ......alive in our memories how he/she touched our lives. We want to take a few moments now to share some of those memories." At this point the one conducting the service might share a personal experience or observations about the deceased, then invite others to share."

This portion will be enhanced if residents are asked a few days prior to the service to prepare a brief message. Some who may feel uneasy about sharing in public may be happy to either write or relate a special memory for you to share on their behalf. Of course, staff should be encouraged to participate in the service as this experience can help create a greater sense of family between caregivers and residents.

Closing

"The second purpose of our service is to remind us of the need to let go. By this we do not mean letting go of the precious memories that we have just shared, but of the painful heaviness of our loss of .... Perhaps we will always feel the sadness over ....'s death, but to hold on to the overwhelming heaviness that would keep us from living our own lives to the fullest would not honor ......'s memory. I'm sure that ....would want us to take comfort in the fact than any unhappiness or suffering is over and will not touch ....again."

The victim of a shipwreck told of her experience of losing all of her possessions: clothing, pictures, everything. For a long time she couldn't stop thinking "Oh if I had only grabbed this or that." Then at a service similar to this the question was asked, "What is it of that which you have lost that you are still holding tightly in your hand? You must let those things go before you can pick up your life again. She, along with other victims, were instructed to write on a piece of paper those things that they were still holding onto. For each it was something different, a picture, a camera, a new watch or some precious keepsake. Then all of the lists were put into a pile and burned. In a sense this is what each of us must do.

After inviting each person to bring to their mind those things which are most difficult, the individual leading the service might give them all to God in the form of a simple prayer.

Note:

If the resident had a favorite song, scripture, or poem, it is always appropriate to include them.

HANDOUT #2

STAGES OF GRIEF

STAGE	**DESCRIPTION**
SHOCK AND SURPRISE	Numbs comprehension; Gives time for response
EMOTIONAL RELEASE	How should my grief be expressed?
LONELINESS	Acute awareness that the person is gone
ANXIETY AND PHYSICAL DISTRESS	Concern over future and/or physical needs
PANIC	Thoughts are immobilized as grief occupies all
GUILT	Questions about what else I could have done?
HOSTILITY AND PROJECTION	Accuses others of wrong judgment
LASSITUDE	Suffering in silence with psychosomatic symptoms, suicide is possible
RESOLUTION OF GRIEF	Working through grief and reestablishing self
READJUSTMENT TO REALITY	Adjustment to changed life status

Note: The stages occur in varying sequences

Note: From Albert, W.C., **The Management of Grief**, (Unpublished, 1979)

HANDOUT #3

INTERVENTION: WORKING WITH THE GRIEVING PERSON

INTERVENTIONS:

- Give support and recognize their losses. It's o.k. to mourn, allow to set own pace
- Allow time alone, to think, review the past, cry, and be angry. To suffer will only feel better when coming to terms with loss
- Be available - be someone who cares; call, visit. Too much isolation can prolong behavior, i.e., hostility and crying and lead to chronic grief.
- Encourage individual to mourn; feelings are normal; it is important and necessary to grieve. Encourage individual to talk about feelings: sadness, fear, hopelessness, anxiety; reminiscence is helpful
- Encourage individual to do more things. You don't have to have all of the answers
- Be an active listener

DON'TS:

- Change the subject
- Deny what has happened
- Be fatalistic "we are all going to die", etc.
- Say "I don't think things are really that bad"
- Be aloof and distant or avoid the resident
- Make the resident feel dependent by doing for them. Allow them to do for themselves

Review this and think about your own feelings toward death and other losses.

SECTION C

DEATH AND DYING

CONTENT:

Background Information................................pg. 30
Exercise #1 - Self Assessment Questionnaire.........pg. 31-32
Group Discussion - Stages of Dying..................pg. 33-35
Exercise #2 - Death and Dying Worksheet.............pg. 36-39
Exercise #3 - Identifying the needs of the dying....pg. 40-41
Handout #1 - Stages of Dying........................pg. 42

SECTION C

DEATH AND DYING

Background Information:

One of the most important tasks of the second half of life is coming to terms with death. This has become far more complicated in recent years as medical science has made great strides in the prolonging of life, and thereby, the prevention of death. Death, in this medical environment is often perceived by physicians, nurses and other caregivers as a professional failure. This attitude prevents us from viewing death as the natural end to life. In this light death is regarded as an event that is unnatural, mysterious, fearful and to be avoided at all costs.

Ironically, this attitude flies in the face of common sense as we all know that we cannot live forever. As caregivers in boarding and nursing homes, we see the residents for whom we care preparing to face the end of their lives. Assisting them in this final transition is an important role for the caregiver. There are ways that we may be of great help.

The first step in being able to help others to accept death is to examine one's own attitudes and feelings about death and the process of dying, and reach some level of acceptance of death as a normal life transition. The goal of this section is to provide opportunities for self discovery through questioning, assessment, and discussion. The quest for understanding and acceptance of death cannot begin and end here, but is an ongoing process for each individual.

EXERCISE #1

SELF ASSESSMENT

QUESTIONNAIRE

OBJECTIVE:

To provide participants an opportunity to explore their own feelings and attitudes about death and to gain an understanding of others' perspectives.

METHOD:

Prior to the session, each person is given a copy of the self-assessment questionnaire to complete. Participants should consider their own reactions to each of the questions. Those who feel comfortable in doing so may share their reactions and opinions during the session.

DISCUSSION:

The primary role of the trainer is to facilitate group discussion about this topic by fostering a non-threatening environment for participants. The trainer should emphasize that there are no right or wrong answers to these questions. The benefit of the exercise lies in enhancing one's understanding of self and others around this topic.

TIME: 15 - 20 minutes

SELF ASSESSMENT

QUESTIONNAIRE

Worksheet

1. How much time and energy have you invested in examining your feelings, beliefs, hopes, and fears about the end of your life?

2. What would your initial reaction be if you were told that you had only a short time to live?

3. Would it change the way you live your life now?

4. Are there things you would feel an urgency to do before you died?

5. Are you afraid of dying? of death?

6. Can you identify the sources of your fears?

7. Consider the imminent death of someone you love. How would you spend your remaining time together? What would you talk about to a loved one who was dying?

8. Are you prepared to cope with all the legal details of the death of a relative?

9. Have you talked with your family about death and dying?

10. Are there things, emotional and practical, that you would feel a need to work out with your parents, children, siblings before your own death or theirs?

Adapted from: Death: **The Final Stage of Growth**,
Elisabeth Kubler-Ross.

GROUP DISCUSSION

THE STAGES OF DYING

An ancient story tells of a servant who was walking in the market place one day. Suddenly, he saw Death in the crowd making a threatening gesture toward him. Frightened, he ran home and told his master to give him a horse that he might flee to Samaria. When asked why, he related to his master the experience of seeing Death's threatening gesture. Given the horse, he rode off toward Samaria. Later that day the master saw Death in the market place and asked him why he made a threatening gesture toward his servant. "Why, that was no threatening gesture, said Death, "It was a look of surprise. You see, I was surprised to see him here because I have an appointment with him tonight in Samaria."

The story teaches the inevitability of death. It tells us in essence that some day we each have an appointment in Samaria. Even though we know this is true and that people have been dying since time began, death is still regarded as an intruder, an enemy, not as a natural part of the life cycle. This is not the case in many other societies of the world. Our attitudes about death are largely the product of a society that has been preoccupied with the "fountain of youth." If people frantically thunder off to Samaria to avoid wrinkles and gray hair how can we expect a healthy attitude about death and dying.

Dr. Elisabeth Kubler-Ross, who is considered the foremost authority in this field, has worked with thousands of dying patients and has written extensively on the subject. In her work she has identified five stages in the process of dying. In our discussions we will consider each of these stages. While the five stages are considered to be an excellent model, it should be noted that we all come from different backgrounds, with different social values, different views of life and God, etc. Therefore not everyone will go through each, or any, of the five stages or grieve a loss in the same way.

FIRST STAGE - DENIAL

We all have an arsenal of defense mechanisms which we use throughout our life. We use these defense mechanisms when we are confronted with situations or issues that bring severe emotional pain. Denial is one such coping mechanism.

We use our most effective defense mechanisms unconsciously, automatically and immediately, thus such responses as "No, not me", "It isn't true," or "Its a mistake - a lie" are common upon hearing the news of a terminal illness. While it is important and healthy for an individual to talk about his or her impending death, denial may prevent him or her from being ready to discuss it.

Caregivers should note that as a defense mechanism, denial is a temporary coping strategy. Denial can become pathological if it continually distorts reality. During this time caregivers should be patient and supportive and help to orient the individual toward reality. Just as in grieving one must accept the reality of another's death, a dying person must accept the reality of his own death.

SECOND STAGE - ANGER

The fact that death is never fair and that timing is always poor is often heard expressed in such exclamations as "Why me?" and "Why now?"

Bearing the brunt of someone's anger can be both intimidating and demoralizing for caregivers and family members alike. The most important thing to remember (and perhaps the hardest thing to do) is to recognize that expressions of anger are not necessarily directed toward you personally but rather the expression of feelings that may have nothing to do with you. A terminal patient's anger may represent a variety of feelings, such as:

(a) **Feelings of Guilt** (The guilt for leaving one's family, for not taking better care of him/herself; "If I had stopped smoking when I was told to," the expense of medical care. Also there is often a sense of shame, "Is this a punishment for some sin?");

(b) **Feeling of Fear** (The fear of dying alone; fear of the unknown); and

(c) **Feeling of Frustration and Futility** (Inability to reverse the condition. The attitude of family or staff's strained cheerfulness or avoidance of the subject).

Note: The instructor may want to further discuss these and other feelings that may be expressed by anger. It may be helpful for the instructor to discuss the importance of responding not to the angry behavior but rather to the feelings which are behind the behavior.

THIRD STAGE - BARGAINING

In this stage the reality of what has happened (or what is to happen) is accepted. The initial shock is over, the anger has allowed some of the intense emotion to be released. A sense of desperation may now come over the individual. He may bargain (with God) for a cure or more time ("If I get well I'll serve you forever." "Let me live to see my grandchildren graduate," etc.).

FOURTH STAGE - DEPRESSION

All of the feelings that were initially expressed by anger may now cause sadness. As one contemplates leaving family and friends there is a tremendous sense of loss. A person may want to talk some during this time but will, for the most part, want and perhaps need to be alone to make emotional preparation for his death.

FIFTH STAGE - ACCEPTANCE

With a supportive environment and time, the dying person reaches a point where he is neither depressed nor angry about his fate. While it may not be a happy time, neither will it be a sad time. It is like the final rest, or in some cases, the anticipation that comes before a long journey.

The patient has found some peace. His circle of interest narrows. He may become selective with who he wants to visit, he may not want to talk much. This is OK and it would be well if both staff and family can accept this and respect the patient's wishes during this time.

EXERCISE #2

DEATH AND DYING

OBJECTIVE:

To assist participant to examine and discuss the feelings and the needs of the dying patient, family members and caregivers.

METHOD:

Five minutes are allowed at the beginning of the session to complete the worksheet (attached). This can be done individually or in groups. The questions are then reviewed and reactions are discussed.

DISCUSSION:

Because many of these questions allow for a wide latitude of right answers the facilitator will want to discuss all points of view. It is also important to capitalize on the experience of the participants by asking "What has worked for you?" "What has been your response to the patient when this happens?" etc.

TIME: 10 - 15 minutes

DEATH AND DYING

Worksheet

1. Because it is such a shock, it is probably best that people not be told that they are terminally ill and are going to die. It is more human to shield them from this for as long as possible?

Strongly Agree Agree Strongly Disagree

2. It is good and healthy for staff, patients and family to express their anger.

Strongly Agree Agree Strongly Disagree

3. Most people who are naturally cheerful and given to humor often change and are sullen around a dying patient. This is good, as humor is not appropriate under the circumstances.

Strongly Agree Agree Strongly Disagree

4. One of the hardest things about being a caregiver is always having to suppress your emotions and hold back tears when you feel like crying. It is not easy being professional.

Strongly Agree Agree Strongly Disagree

5. If you have suffered an illness or loss similar to that of a patient or family member it is always helpful to share your experiences. It makes people feel better to hear "I know exactly how you feel."

Strongly Agree Agree Strongly Disagree

6. It will make a difference in the quality of your care whether you view death as the beginning of the end or as a continuing stage of life.

Strongly Agree Agree Strongly Disagree

EXERCISE #2

DEATH AND DYING

WORKSHEET TRAINER'S GUIDE

1. **Because it is such a shock it is probably best that people not be told they are terminally ill and are going to die. It is best to shield them from this for as long as possible.**

While it is extremely important to keep honesty in the relationship, patients do tend to fare much better if every ray of hope is not taken from them. To the questions "Am I going to die?" a response might be, "Nobody knows when we are going to die and while you are very sick we are going to do everything possible to help you." However, it should be remembered that people do need to accept the reality of their own death and that deception can ultimately cause both patient and staff to feel much guilt and grief. One must allow for individual variations in this area.

2. **It is good and healthy to express, to allow and to accept anger from staff, patient and family.**

This question has many parts. The instructor will need to explore the reasons participants might need to express anger. How can they express it and to whom. Anger is a very prevalent emotion during the initial stages of death and dying and a difficult one to define as it can take so many directions.

(a) The staff person may feel so uncomfortable around a dying patient that they avoid the patient and feel both guilt and anger at themselves;

(b) The family member may feel guilt for placing the loved one in the nursing home or because the loved one is suffering and not them;

(c) The family may express anger toward staff for not giving "better care;"

(d) The patient may be angry at his/her circumstances and direct anger toward staff.

Probably the most difficult thing for staff is to recognize the feelings behind the anger and not take it personally. A simple expression like "It must be very difficult or frightening for you right now" or "It must be frustrating for you to feel helpless while your mother is going through this" might open the door through which some of these feelings can be expressed.

3. **Most people who are naturally cheerful and given to humor often change and are sullen around a dying patient. This is good as humor is not appropriate under the circumstances.**

This question is included to remind participants of three important thoughts:

(a) People who are dying become extremely sensitive to their environment and are often keenly aware when voices lower or when heads turn away;

(b) The importance for caregivers to keep reality in their relationships; and

(c) The question stated "naturally cheerful;" practice being yourself.

4. **One of the hardest things about being a caregiver is having to always suppress your emotions and hold back the tears when you feel like crying. It's not easy being a professional.**

This question is designed to examine appropriate feelings and responses on the part of caregivers. What does being a "professional" mean and not mean in terms of expressing emotion. There are times when crying may in fact give the patient permission to cry.

5. **If you have suffered an illness or a loss similar to that of a patient or family member you should always share your experience. It makes people feel better to hear "I know exactly how you feel."**

Most people resent hearing such phrases as "I know exactly how you feel." If the caregiver did not know the deceased or dying person, he could never have truly appreciated the losses that one who had a close relationship felt. The instructor should discuss the sensitivity called for in these matters. Caregivers should always respect the "special" circle around each family. Our own experience can, however, be used in a therapeutic way by saying "When this happened to me, I felt.......perhaps you might be feeling the same."

6. **It makes a difference in the quality of your care whether you view death as the beginning of the end or as a continuing stage of life.**

The instructor should discuss with the group how a person's view of death translates into the care of one who is dying. If a patient believes that he has no gifts to give, what will that do to his spirit? It should be pointed out that perhaps the ultimate loss is the loss of the capacity not to get but to give love, to feel useful, to make contributions. The simple act of saying thank you to a patient for the smile or something they said, or did can serve to reinforce the idea that the patient gave a small gift that was appreciated.

NOTE TO INSTRUCTOR:

Reaction worksheets are often good tools to generate discussions. After assessing your training needs, the instructor might add questions which will address issues that are particularly relevant in your own facility.

EXERCISE #3

IDENTIFYING

NEEDS OF DYING

OBJECTIVE:

To heighten participants' awareness of the needs of dying residents in the context of Maslow's Hierarchy of Needs.

METHOD:

The five human needs, according to Abraham Maslow, are recorded on a flip chart or black board at the beginning of this exercise to be used as a guide (the five needs are listed below). Participants are asked to select a specific resident at the facility and to think about the needs of that resident from the perspective of those noted on the flip chart or blackboard. Participants are then asked to list on paper (either individually or in groups) those needs and be prepared to share them during group discussion.

DISCUSSION:

Maslow suggested that in order for individuals to grow fully as human beings, they must first realize five basic needs. This is especially important for the dying patient, whose primary needs are often physical and emotional in nature. Caregivers should be continually aware of these needs and of what they can do to help the dying resident to address those needs when they are not being clearly expressed.

The following is a list of Maslow's five basic human needs, accompanied by a few examples of each to be used as a guide in this exercise.

Physiological Needs

(a) food, drink and shelter

(b) avoidance of injury, pain, discomfort, disease, and fatigue, etc.

(c) need for sensory stimulation (sight, sound, touch, etc.)

Safety Needs

(a) orderliness and familiarity of objects.

(b) to finish business such as conveying messages or last instructions to loved ones.

(c) having familiar people around - that they will not be abandoned by family and/or staff in their final moments.

Love Needs

(a) love and affection of loved ones and friends

(b) still being considered as an important part of a significant group

(c) does not feel rejected when needing to express thoughts, emotions, etc.

(d) is not isolated at the end of life

Esteem Needs

(a) feeling esteemed, recognized for how they have lived

(b) to be given attention and acknowledgment in their last moments

Self Actualization

(a) feeling that one has been accepted by family and friends

(b) feeling of accomplishment

(c) feeling that deeds have been accomplished as wanted

(d) given the opportunity to take care of unfinished business

(e) Feeling of relief, relaxed

TIME: 20 to 25 minutes

HANDOUT #1

STAGES OF DYING

DENIAL

"No, not me!" This is a typical reaction when patients learn that they are terminally ill. Denial, says Dr. Elisabeth Kubler-Ross, is important and necessary. Denial helps cushion the impact of the patient's awareness that death is inevitable.

RAGE AND ANGER

"Why me?" The patient resents the unfairness that others will remain healthy and alive while he must die. God is a special target for anger since he is regarded as imposing, arbitrarily, the death sentence on the individual. To those who are shocked at her claim that such anger is not only permissible but inevitable, Dr. Ross replies succinctly "God can take it."

BARGAINING

"Yes, me, but........" Patients accept the fact of death but strike bargains for more time. Mostly they bargain with God..."even people who never talked with God before." They promise to be good or to do something in exchange for another month or year of life. "What they promise is totally irrelevant, because they don't keep their promises anyway."

DEPRESSION

"Yes, me." First, the person mourns past losses, things not done, and wrongs committed. Then he enters a state of "preparatory" grief, getting ready for the arrival of death. The patient grows and may not want visitors. "When a dying patient doesn't want to see you anymore, this is a sign that he has finished his unfinished business with you, and it is a blessing. He can now let go peacefully."

ACCEPTANCE

"My time is very close now and it's all right." Dr. Kubler-Ross describes this final stage as "not a happy stage, but neither is it unhappy. It's devoid of feelings, but it's not resignation, it's really a victory."

(Kubler-Ross, 1975)

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OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION A: Change & Loss			
1. Participants will be sensitized to the many emotions which accompany an important loss.	Exercise #1 The Emotional Impact of Loss	Self-Assessment and Group Discussion	15-20 minutes
	Exercise #2 Change & Loss	Life Change Scale & Group Discussion	15-20 minutes
	Exercise #3 The Experience of Loss Worksheet	Worksheet and Group Discussion	W/Worksheet complete 10 mins.
2. Participants will discuss the special significance of loss as it relates to elderly people.	Exercise #4 "Compassion... I Suppose"	Videotape	25 minutes
	Exercise #5 Losses and Feelings experienced by NH/BH residents	Worksheet & Group Discussion	10-15 minutes
3. Participants will identify physical and behavioral changes that can accompany multiple and overlapping losses.	Exercise #6 Loss and the Elderly	Individual Reaction & Group Discussion	25-30 minutes
SECTION B: Grief			
1. Participants will discuss the grieving process as it relates to loss and death.	Group Discussion Tasks of Mourning	Group Discussion	20-25 minutes
2. Participants will discuss interventions to help residents cope with the death of a friend, family member, or fellow resident.	Group Discussion Tasks of Mourning	Group Discussion	20-25 minutes

OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION B: Grief (Con't)			
3. Participants will examine their own attitudes about death and the coping skills used in dealing with loss.	Exercise #1 Personal Grief History	Self-Assessment & Group Discussion	W/worksheet complete 10-15 minutes
SECTION C: Death & Dying			
1. Participants will review the stages of death & dying.	Exercise #1 Self-Assessment Questionnaire	Self-Assessment & Group Discussion	15-20 minutes
	Group Discussion The Stages of Dying	Group Discussion	20-25 minutes
2. Participants will discuss death from the perspective of being the final stage of the normal life process.	Group Discussion The Stages of Dying	Group Discussion	20-25 minutes
3. Participants will discuss the range of feelings experienced by terminally ill people.	Exercise #2 Death and Dying	Worksheet & Group Discussion	W/worksheet complete 10-15 minutes
	Exercise #3 Death and Dying	Group Discussion	10-15 minutes

GERIATRIC

EDUCATION

&

RESOURCE

OUTREACH

UNIT #3

DEPRESSION

UNIT #3

DEPRESSION

Unit #3 is an introduction to the topic of depression, the most common emotional illness associated with the aging process. Focusing primarily on older residents of long-term care facilities, this unit discusses the signs and symptoms of depression, the most commonly practiced treatments and interventions, and suicide as a component of depressive illness.

Section A addresses some of the warning signs and symptoms of depressive behavior among older nursing and boarding home residents. Section B focuses on suicide, and section C includes a discussion of the various intervention strategies used in caring for elderly residents who are depressed.

Because depression is so common among older persons and increases as a result of losses sustained in later years, it is important for caregivers to gain an understanding of the ways in which they may help elderly residents in coping with those feelings. Participants will be given the opportunity to share and discuss helping interventions through a variety of exercises and activities.

OBJECTIVES:

Section A	To identify the most common signs and symptoms of depressive behavior among elderly residents.
	To identify and discuss the range of feelings common among elderly residents who appear depressed.
Section B	To identify the risk factors associated with suicide among elderly people.
	To identify caregiving interventions for residents who are at risk.
Section C	To review therapeutic interventions for residents who are depressed.
	To discuss anti-depressant medications and their side-effects, especially as seen among elderly people.

CONTENT:

Section A - Signs and Symptoms of Depression.......pp. 1-10

Section B - Suicide.............................pp. 11-28

Section C - Interventions........................pp. 29-44

SECTION A

DEPRESSION AND THE ELDERLY RESIDENT

CONTENT:

Background Information ....pp. 2-3

Exercise #1 - Behaviors Common among Depressed Residents ....pg 4

Exercise #2 - Symptoms of Depression ....pp. 5-6

Handout #1 - Behaviors Commonly Associated with Depression ....pp. 7-8

Handout #2 - Medical Disorders that Cause or Mimic Depression ....pg. 9

Handout #3 - Types of Drugs that Cause or Mimic Depression ....pg. 10

DEPRESSION AMONG

THE ELDERLY

Background Information:

Depression is the most common emotional illness associated with old age. Fortunately, it is also the most treatable. More than half of all persons aged sixty and older will suffer from a serious episode of depression at least once. Statistics indicate that between 30-80% of all persons living in long-term care facilities have experienced episodes of depression. While it is diagnosed twice as often in older women, suicide rates are dramatically higher among older men.

Depression is often mistakenly considered as a natural part of the aging process. Certainly as we age losses and changes related to those losses do increase. This can cause much stress at a time when strength, energy, and support systems needed to cope are diminished. Because of this, the likelihood of experiencing an episode of depression increases as individuals grow older. This is different from the notion that depression is a "normal" part of growing older. Regarding depression as the norm may mean that treatment will not be sought for the older resident, thus forcing the individual to experience a poorer quality of life as well as the ultimate risk of depression, suicide. This scenario is made more tragic by the fact that depression is treatable.

In general, depression which is seen among residents in long-term care facilities develops from three major sources:

1. Depressive conditions that have been life-long occurrences.
2. Depression as a response to multiple losses experienced as a result of aging and circumstances requiring a move to a long-term care setting.
3. Depression which is secondary to a specific disease process and/or medication.

Primary caregivers have the best advantage to notice changes in behavior which may signal the onset of depression. Depression can show itself in many forms: one resident may be found sitting alone, withdrawn, and unable to participate in the flow of activity around him or her, while another resident may be agitated, anxious, angry, and difficult to be around. Untreated depression can begin to mimic dementia. Symptoms of untreated depression that resemble dementia include disorientation, memory loss, inability to concentrate, loss of interest in the environment, and withdrawal.

One major role of the caregiver is to report changes in the behavior of residents in an accurate and timely manner. Through empathetic listening, the caregiver may observe other clues as to what may be precipitating behavior changes (bad news from home, death of a friend, etc.). Concern, care, and understanding are messages that need to be conveyed to the resident who is depressed. This kind of attention, both verbal and non-verbal, is essential to the resident who, in fact, may feel unaware of such attention.

Working with residents who are depressed can be a frustrating experience for the caregiver. Overtures of care and concern may be consistently rejected by the resident. It is very difficult not to take this rejection personally. Feelings of anger, frustration, and, most of all, a sense of failure are common among caregivers. Yet, it is critically important to remember that the time at which the caregiver feels most like giving up is the very time at which the depressed resident is most in need.

Risks of Depression

The most serious risk for depression is suicide. Because of the high incidence of depression and suicide among elderly people, Section B addresses suicide at length. There are, however, other equally lethal, though less immediate risks of depression.

One important risk is malnutrition. People who are depressed often claim that they have no appetite. Food which at one time tasted good may have lost its appeal. In fact, some persons who are depressed experience a bloated, full feeling all of the time (the way one feels after eating Thanksgiving dinner). Gastric motility slows down and constipation results. Malnutrition is a distinct possibility if this situation continues for an extended period and may be further complicated by multiple medications whose effects will rapidly change without adequate nourishment and hydration.

Also, persons who are depressed are often disinterested in personal hygiene. Poor hygiene places the resident at greater risk for infection which is an even more serious problem for elderly persons whose health is already compromised.

Further, inactivity which results from feelings of depression contribute to physical illness due to the hazards of immobility; pneumonia, poor circulation, pressure sores and constipation, etc.

In addition, the slowing of thought, which often accompanies depression, can be dangerous when it prevents a person from staying out of harm's way, e.g., the resident who ignores the fire bell.

Finally, decreased sensory input, which occurs as a result of the depressed person's isolation and withdrawal, can contribute to negative cognitive and emotional changes (confusion, paranoia, and loss of memory, etc.). For the older depressed resident this can trigger a series of events which may leave the resident with the label of dementia.

EXERCISE #1

BEHAVIORS COMMON AMONG DEPRESSED RESIDENTS

OBJECTIVE:

To help participants to identify behaviors that are common among residents suffering from depression.

METHOD:

Participants are divided into small groups. Each group, drawing on their own experiences at the facility, are instructed to compile a list of signs and symptoms that are indicative of individuals who are suffering from depression.

DISCUSSION:

Some of the most common signs of depression include:

(a) Feeling tired all of the time
(b) Lack of interest in the environment - appears not to notice
(c) May sleep all of the time
(d) Loss of appetite
(e) Either loss or gain in weight
(f) Feels irritable
(g) Unable to concentrate
(h) May feel sad without any reason
(i) Unable to enjoy anything
(j) Many complaints related to physical problems without any apparent causes
(k) Crying without reason
(l) Angry outbursts
(m) Feels and acts slowed down
(n) Withdraws from environment

It may be noticed that the resident stays in bed curled up with back towards the door or sits in the day-room with head down, hands clenched. When able to walk, she will do so very slowly without energy. She may refuse food. Depressed individuals may refuse medication and any attempts to stimulate them or motivate them to participate in activities.

TIME: 10 - 15 minutes

EXERCISE #2

SYMPTOMS OF DEPRESSION

OBJECTIVE:

To assist participants in recognizing symptoms that may indicate depression.

METHOD:

Participants are given the attached handout, which lists a variety of behaviors, and are asked to identify those that they feel may be symptomatic of depression. Group discussion follows.

DISCUSSION:

Participants usually arrive at the correct conclusion that any or all of the symptoms listed may indicate a depressed mood. Attention should be drawn to the fact that many of the symptoms could be related to other problems as well.

The trainer should make note of how many of the symptoms are the same as those we associate with dementia, i.e., agitation, confusion, disorientation, difficulty with concentration, and memory loss. Care should be taken to emphasize that none of these symptoms are normal factors of the aging process and that they indicate problems which must be identified and treated.

The symptoms of depression that are most characteristic of the elderly resident who is depressed include: insomnia, weight loss, hopelessness, constipation, problems with digestion, loss of pleasure or interest in usual activities, and increased focus on physical ailments.

Feelings of worry, uselessness, sadness, pessimism, and fatigue are also characteristic. There is also a "paralysis of will" that may lead to social withdrawal which may in turn reinforce the other symptoms.

TIME: 10-15 minutes

EXERCISE #2 (Cont.)

SYMPTOMS OF DEPRESSION

WHICH OF THE FOLLOWING SYMPTOMS INDICATE DEPRESSION?

___ FATIGUE

___ CRYING SPELLS

___ INSOMNIA

___ AGITATION

___ WEIGHT LOSS

___ WEIGHT GAIN

___ CONFUSION

___ IMPOTENCE

___ FEELINGS OF HOPELESSNESS

___ UNKEMPT APPEARANCE

___ EXCESSIVE DRINKING

___ DISORIENTATION

___ FEELINGS OF WORTHLESSNESS

___ DIFFICULTY CONCENTRATING

___ IRRITABILITY

___ BOREDOM

___ CONSTIPATION

___ MEMORY LOSS

___ SUICIDAL THOUGHTS

___ FEELINGS OF ISOLATION

___ ANGER AND HOSTILITY

___ PROBLEMS WITH DIGESTION

___ EARLY MORNING
WAKEFULNESS

___ SEXUAL DISINTEREST

___ FEELINGS THAT OTHERS GET
PREFERENTIAL TREATMENT

___ LOSS OF PLEASURE IN
USUAL ACTIVITIES

___ MUCH DISCUSSION OF
PHYSICAL AILMENTS

HANDOUT #1

BEHAVIORS COMMONLY ASSOCIATED WITH DEPRESSION

EMOTIONAL

- Sadness
- Crying
- Apathy (Lack of Feeling)
- Feeling "Blue"
- Feeling Depressed
- Feeling Despondent
- Low Self-esteem
- Guilt
- Being "Down in the Dumps"
- Being Unhappy
- Decreased Pleasure or Enjoyment
- Lack of Interest
- Decreased Life Satisfaction
- Denial of Feelings
- Sense of Personal Worthlessness
- Rejected

CHANGES IN THINKING

- Pessimistic
- Inability to Concentrate
- Feeling of Uselessness
- Uncertainty
- Disoriented
- Hopelessness
- Self-blaming
- Confusion
- Rumination About Past Failures
- Suicidal thoughts
- Decreased Attention Span
- Loss of Interest and Motivation
- Helplessness
- Self-depreciation

PHYSICAL SYMPTOMS

- Sleep disturbance
- Loss of Appetite
- Weight Loss or Weight Gain
- Fatigue
- Overeating
- Constipation
- Chest pain
- Many Physical Complaints
- Headaches
- Backaches
- Loss of Sexual Interest
- Vomiting
- Lassitude
- Indigestion

BEHAVIORAL CHANGES

- Reduction in Activities
- Agitation
- Irritability
- Angry or Hostile Behavior
- Aggressiveness
- Tearfulness
- Withdrawal
- Lack of Spontaneity

HANDOUT #2

MEDICAL DISORDERS THAT CAUSE OR MIMIC DEPRESSION

HYPER OR HYPOTHYROIDISM

DIABETES WITH HYPERGLYCEMIA

MALIGNANCIES

CUSHING'S DISEASE (HYPERADRENALISM)

CONGESTIVE HEART FAILURE

HYPERCALCEMIA

PARKINSONS DISEASE

ANEMIA

DEHYDRATION

POLYMYALGIA RHEUMATICA

CENTRAL NERVOUS SYSTEM

Brain Tumors

Subdural Hematomas

Cerebro Vascular Accidents (Strokes)

HANDOUT #3

TYPES OF DRUGS THAT MAY CAUSE OR MIMIC DEPRESSION

ANTIHYPERTENSIVES

CIMETIDINE

L-DOPA

NEUROLEPTICS

HYPNOTICS

STEROIDS

DIGITALIS

NON-STEROIDAL ANTI-INFLAMMATORY AGENTS

TRANQUILIZERS

SECTION B

SUICIDE

CONTENT:

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Exercise #3 - Helping Strategies ....pg. 20

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SUICIDE

Background Information:

A discussion of suicide is included within this unit on depression because an estimated sixty percent of those who take their own lives have either been diagnosed with, or have demonstrated signs of, depression prior to their deaths.

One study of suicide conducted in a large urban area revealed that fifty percent of those diagnosed as being depressed had visited their physicians a short time preceding their death. The study revealed that even though diagnosed as depressed, the physicians had underestimated the risk of suicide and failed to take adequate precautions against it. It is generally assumed that only severely depressed persons commit suicide. Actually, a significant number of persons with mild to moderate depression attempt to take their own lives. The only safe course is to regard all depressed patients as potentially suicidal.

Current statistics indicate that suicide is on the rise at an alarming rate. While we do not know all the reasons why, it is recognized that people with certain types of problems are more likely to commit or attempt suicide.

1. People who have manic-depression (bipolar illness) have the highest reported rates of completed suicide.

2. People with psychosis are more likely to complete suicide than the average person who makes an attempt.

3. People who have a history of difficulty handling feelings and relationships or losses are more likely to attempt suicide but have the lowest rate of completed suicides.

4. Family history of suicide.

While suicides among all ages are on the increase, statistics indicate that people who are aged 65 and older more often take their lives. Reasons why this may be true include: retirement, which may bring on role loss, loneliness, loss of spouse, and diminishing health.

More men than women commit suicide. Statistics tell us that after the age of 65, the ratio is four to one. After age 85 the ratio increased to twelve to one.

It should be noted that, statistically, it is white males that constitute the largest number of suicides among the older population. Rates among older women are not significantly higher than other age groups. Another sobering fact that may help to explain the high suicide rate among elderly people is the high rate of completed suicides among this group. Elderly people are the only age group in which the successful suicides outnumber the attempts. When elderly people are suicidal, they are more likely to be successful in ending their lives than younger age groups.

GROUP DISCUSSION

SUICIDE

It is important to understand suicide as a sign of intense pain. People with suicidal tendencies and ideations have a great need to be cared for and helped with whatever is causing this pain.

Seldom does suicide occur without warning. Caregivers who work with residents on a daily basis have the unique opportunity to intervene before a potentially suicidal person reaches a state of crisis.

Warning Signs

All individuals have a threshold to pain, a point beyond which toleration is no longer possible. One who has endured a particularly long and/or severe bout of depression is, therefore, someone who merits much concern and attention from caregivers. In addition the following individuals are considered to be most at-risk for suicide:

1. Males
2. Individuals aged 65 and older
3. Individuals who are divorced, widowed, separated, or living without family;
4. Those who have experienced a recent loss of spouse, family member or close friend.

Note: An improvement in mood or energy level following a prolonged period of depression does not mean that a suicide risk has ended. Statistically, a large number of suicides occur within ninety days after the beginning of improvement. It is often during this time that a person has the energy to put their thoughts and plans into action.

Marked Changes in Behavior or Personality

The facilitator may wish to review handout #3, **Warning Signs of Suicide**, in preparation for this part of the discussion, or as a part of the discussion.

Note: Often times, changes in mood and activity level may be seen in patients during the early stage of treatment with an anti-depressant medication.

A Previous Suicide Attempt

All suicidal threats should be taken seriously. Any individual with suicidal ideations is extremely desperate. Previous suicidal attempts are cause for even greater concern, even if those attempts appear to have been motivated by the need for attention. If needs go unmet, another more serious attempt may follow.

Suicidal Threats or Similar Statements

The idea that people who talk about suicide never commit the act is a myth. Eight out of ten people who attempt suicide do give some verbal and/or other clues about their intentions. Such direct statements as "I won't be around much longer for you to put up with," or "I wish I were dead," or "My family would be better off without me," should alert the caregiver to the possibility of a suicide attempt. Other clues may include:

1. Getting wills and insurance papers in order;
2. Giving away possessions;
3. Inquiring about funeral arrangements.

HELPING STRATEGIES

Having reviewed the warning signs of suicide and considered some of the basic characteristics of a suicidal person, it is important to think about ways in which caregivers can intervene.

> **Note:** As an option to Exercise #3 the facilitator may wish to review the House policy on suicide. Included as Handout #2 is a sample policy from a state-run psychiatric hospital.

1. Ask Questions

If someone in distress goes to the doctor, the first questions asked are "Are you in pain?," and "Where does it hurt?" With this knowledge the helping process begins. If someone who is emotionally distressed is contemplating suicide, the most effective action is to talk freely, asking frank and direct questions about suicide. Some are reluctant to do this and may think that talking about suicide will "plant" the thought in the individual's mind, making it potentially dangerous to discuss such concerns. However, it is unlikely that an individual would commit suicide simply upon hearing the idea.

Others believe that if an individual were planning to take his or her life, he or she would not want to talk about it. Many individuals will, however, welcome an earnest inquiry for the following reasons:

1. Many people are ambivalent about dying and really desire to be rescued. We can see this, even in the experience of "The Jumper (see exercise #2 and Handout #4):"

> ..."I got to the other building by catwalk, sure that someone would see me, you know, out of all those windows. The whole building is made out of glass."

2. Harboring such thoughts can be an energy draining experience. It is often a great relief to get suicidal thoughts out "in the open."

3. If you can impress a person, through earnest inquiry, that even one person cares about him or her, this in itself may be enough to turn them away from the suicide.

Questions should be about:

1. **Feelings** "Mrs. Smith I have noticed you are staying by yourself more and more. You seem so unhappy, you hardly touch your food. Can you tell me what you are feeling?"

2. **Thoughts** "I have been so concerned that I have wondered if you have had thoughts of hurting yourself."

3. **Plans** "Have you had thoughts about suicide? How would you do it?"

Note: As a rule, the more detailed the thought that has gone into the plan, the greater the risk.

2. GIVE OTHER OPTIONS

Because the person who would take their life is blinded to other options, hope should be instilled by providing choices. Following is a suggested line of questioning which may help someone to think through a problem.

1. "What would have to change in order for things to be better for you?" "What would make you happy?"

2. "Let's make a list of the things that you have, and do not have control over."

3. "Let's review some of the things that you can change." "How can we help?"

4. "Remember, you always have the option to take your life, but for now let's look at other choices. There are people here who care, who want to help you work things out."

Remember, if an individual is willing to listen, consider and weigh the choices, this in itself may be therapeutic. The caregiver may have ignited a ray of hope.

3. SECURE A PROMISE

The caregiver may reinforce his or her concern by urging, from the client, a promise that they will do nothing to harm him or herself.

Note: Caregivers themselves should never make promises that cannot be kept. Unkept promises only reinforce in the individual's mind that he or she is worthless and that nobody cares.

Note: Caregivers should never hold themselves responsible for acts of suicide. In some cases no clear signs are given. A person determined to take his or her own life will find a way to succeed despite any attempts at intervention.

4. REPORT INFORMATION TO SUPERVISOR AND OTHER STAFF IMMEDIATELY

Risk should never be ignored. Immediate precautions should be initiated by staff. Arrangements should be made for an evaluation by a professional.

In summary you have assured that you want to help by....

1. Opening a line of communication
2. Suggesting other options
3. Offering hope
4. Demonstrating that you care

Note: Instructor may review other helping strategies for dealing with suicidal behavior contained in the handout materials as time permits.

EXERCISE #1

ATTITUDES

ABOUT SUICIDE

OBJECTIVE:

To sensitize participants to their own attitudes (as well as prevalent societal attitudes) about suicide.

METHOD:

The facilitator initiates a discussion of attitudes toward suicide by asking the question "Have you ever known anyone who has attempted or actually committed suicide?"

Note: If no participants have had such an experience, the facilitator may ask "What is one word that comes to your mind that would describe a suicidal person?"

DISCUSSION:

1. What was your initial reaction to the incident?
2. What were your feelings about that person at the time?
3. How did those around you act? What comments were made which now stand out in your mind ?
4. How did you feel the next time you saw that person (if an attempt)?

TIME: 10 - 15 minutes

EXERCISE #2

THE JUMPER

OBJECTIVE:

To help participants to identify and understand important characteristics of a suicidal person.

METHOD:

Included as handout #1 is a personal testimony of a failed suicide attempt. Facilitator instructs participants to read "The Jumper" then, individually or in small groups, underline the portions that would indicate....

1. That the suicidal person is in intense psychological pain
2. Elimination of all other options - death is the only way out
3. A desire (deep inside) to be rescued

DISCUSSION:

1. **"The Jumper"** - "I was so desperate. I felt, my God, I couldn't face this thing. Everything was like a terrible whirlwind of confusion. And I thought to myself there's only one thing to do. I just have to lose consciousness; that's the only way to get away from it."

2. **Intense Pain** - The suicidal person is in intense psychological pain. Therefore, the immediate goal of the caregiver is to reduce the level of pain in any way possible. Interventions must be tailored around whoever or whatever is causing the pain. From the jumper's statement, the pain and extreme urgency to be released from it is obvious.

3. **"The Jumper"** - "...Everything got very dark all of a sudden, and all I could see was the balcony. Everything around it just blacked out. It was just like a circle."

4. **Tunnel Vision** - The suicidal person can see no other solution to his problem. He has come to the place in his thinking where death is seen as his only option. The second goal of the caregiver, therefore, is to provide options, to open a ray of hope in the midst of darkness.

5. "**The Jumper**" - ".. I got to the other building by catwalk, sure that someone would see, you know, out of all those windows. The whole building is made of glass".

6. **Desire for rescue** Most people are ambivalent about dying and, deep inside, harbor desires to be helped. However in their state of mind, they do not know how to reach out.

TIME: 10 - 15 minutes

EXERCISE #3

HELPING STRATEGIES

OBJECTIVE:

To acquaint participants to basic suicide intervention techniques

METHOD:

The facilitator should divide participants into a few small groups and present the following scenario: "You are a caregiver and have developed strong concerns about a resident who you suspect may be suicidal. What can you do to help?" Ask the group to make a list of helping strategies that they would use. Have one person in each group record the ideas then discuss the list in conjunction with materials used in the group discussion.

DISCUSSION:

To Include section on "Helping Strategies" as outlined in the group discussion materials.

TIME: 15 - 20 mins

HANDOUT #1

THE JUMPER

The Jumper. "I was so desperate. I felt, my God, I couldn't face this thing. Everything was like a terrible whirlpool of confusion. And I thought to myself: There's only one thing to do. I just have to lose consciousness, that's the only way to get away from it. The only way to lose consciousness, I thought, was to jump off something good and high.

"I figured I had to get outside....I got to the other building by walking across a catwalk, sure that someone would see me, you know, out of all those windows. The whole building is made of glass.

"I just walked until I found this open staircase. As soon as I saw it, I made a beeline right up to it. And then I got to the fifth floor and everything just got very dark all of a sudden, and all I could see was this balcony. Everything around it just blacked out. It was just like a circle.

"I climbed over it and then I just let go. I was so desperate. Just desperation, and the horribleness and the quietness of it. There was no sound. And I sort of went into slow motion as I climbed over the balcony I let go and it was like I was floating. I blacked out. I don't remember any part of the fall."

From: Point of No return. Edwin Shniedman, **Psychology Today**, March, 1987.

HANDOUT #2

SUICIDE POLICY

The following is a policy on suicidal behavior at a State-run psychiatric hospital in Maine

A. PURPOSE

Suicidal thoughts and behavior are phenomena that occur among people with mental illness. Lethality of suicidal patients fluctuates. The following procedures and precautions are to provide for the safety of these patients.

B. PROCEDURE

1. Suicide precautions may be instituted by any staff member when there is an indication that the safety of the patient is threatened.

   Staff should report all signs of suicidal thinking to the appropriate charge person, and record these observations in the patient's progress notes.

2. A physician or R.N. shall be responsible for prescribing suicide precautions on the patient's chart (doctor's order sheet and progress note) as soon as possible after precautions are initiated.

3. Suicidal precautions may be discontinued only by a physician.

4. Only employees who have had prior preparation in care of the suicidal patient shall be assigned to give one-to-one supervision.

5. Patients on suicidal precautions shall not be allowed trial visits or be discharged.

C. SUICIDAL PRECAUTIONS

1. A team member shall be assigned by the appropriate charge person to give constant one-to-one supervision.

2. **One-to-One Supervision** means that an assigned staff member keeps the patient constantly in sight and has no other duties.

3. All Patient's personal belongings shall be thoroughly **searched**, with patient present, if possible. This search is to be documented in the patient's progress notes.

4. All sharp instruments, hangers, poisonous substances, glass containers, or other potentially dangerous articles shall be removed from the patient and his/her environment.

5. The patient's total physical environment (baths, adjoining rooms, windows, etc.) shall be inspected frequently to ascertain that no dangerous articles are inadvertently present.

6. Removal of articles shall be documented and articles shall be returned when suicidal condition no longer exists.

D. **OTHER LEVELS OF OBSERVATIONS**

If an individual is not an acute suicidal risk but someone about whom there is concern about suicidal potential, supervision of less constancy than one-to-one may be instituted, i.e., Close observation: 15-minute checks or close observation; 30 minute checks or close observation; 60-minute checks.

WHAT TO DO IF A SUICIDE ATTEMPT IS DISCOVERED

A. **SUMMARY:**

Stay with patient

Call (shout) for **HELP**

Act immediately to give emergency aid

Resuscitate if appropriate

Exit after emergency care has arrived

Debrief and document

B. **SPECIFICS:**

1. To get more help, someone should dial 333. Tell the operator:

    a. Page a Code 99 (medical emergency)

    b. STAT help needed (if needed)

    c. Patient's location, e.g. Stone North Middle, Section #2

2. Emergency Aid:

    a. If found hanging, relieve body pressure, cut down, and administer mouth-to-mouth resuscitation.

    b. If found drowning, remove from water and administer mouth-to-mouth resuscitation.

    c. If found bleeding, apply pressure to stop hemorrhage.

    d. Where suspicion of ingestion of poison, try to determine the nature of the poison ingested and inform the emergency care staff. Nature of the poison and symptoms noted determine the type of treatment.

e. In the event of fire, place the alarm immediately unless the fire is small enough for you to put it out by yourself.

3. After emergency care staff has arrived, notify the Unit Director or N.O.D. This individual will ascertain that the necessary documentation will be completed by appropriate (involved direct care) staff in narrative form.

4. Documentation:

In the patient's chart - write progress notes:

a. Patient's behavior preceding attempt, starting from the beginning of the working shift on which the attempt occurred.

b. Events immediately preceding attempt.

c. Exact time, how, and by whom the patient was found; description of condition before any action or treatment occurred.

d. Call for help by whom, when (include when operator notified.)

e. What emergency measures were taken, when, and by whom.

f. Who arrived, when, who took charge of what.

g. Notification of family by appropriate person.

HANDOUT #3

SUICIDAL WARNINGS

Five Warnings Signs of Suicide:

1 Prolonged depression.

2. Marked changes of behavior or personality.

3. A previous suicide attempt.

4. Making final arrangements as though for a final departure.

5. Suicide threats or similar statements.

Behaviors to Watch for:

* Feelings of emptiness
* Hopelessness
* Helplessness
* Fatigue
* Sadness
* Lowered self-esteem
* Feelings of worthlessness
* Decreased interest personal appearance
* Lack of communication
* Decreased interest in surroundings and work
* Sleep disturbances
* Decrease in muscle tone
* Slumped shoulders
* Slowing of gait
* Slowing down of thinking, comprehension and verbal responses
* Feelings of rejection
* Difficulty concentrating
* Disinclination for usual pursuits
* Neglect responsibilities
* Self-accusation
* Loss of appetite and weight loss
* Feelings of loss, shame, or disappointment
* Request for sleeping pills
* Preoccupation with death
* Selection of reading material about death

HANDOUT #4

DEALING WITH SUICIDAL BEHAVIOR

There are several things which can be done when you see one or more signs of suicidal thinking in a resident and think that he may be suicidal. The key thing you're trying to do is get more information about how he is feeling and thinking. In other words, is he suicidal?

1. **Accept the possibility that the person may really be suicidal.** Don't convince yourself that the person isn't the type to commit suicide. Remember that suicide happens to all kinds of people. Also keep in mind that you are working with a group of people who, according to statistics, are more likely to consider suicide.

2. **Do not be judgmental.** Once the person hints that he has been thinking about suicide, or comes right out and says it, it is important not to be judgmental. Do not say "That's terrible," or "You should be ashamed of yourself," or "Don't talk that way."

3. **Don't be afraid to talk about it openly and calmly.**

4. **Be empathetic.** Let him know you understand how badly he feels, even though you believe there are other things he can do besides suicide.

5. **Talk freely.** Don't be afraid to say the word "suicide" or to directly ask him if he is thinking about hurting himself. Saying the words out loud never made anyone suicidal.

6. **Ask Questions.** Questions should be about:

   Feelings
   Thoughts
   Plans (How? When? Where?). In general, the more specific the plan, the greater the risk.

7. **Be affirmative, but supportive.** Strong, stable guideposts are needed in the life of an unhappy individual. Give emotional strength by giving the impression that you know what you are doing and that everything possible will be done to assist the person. Let him know that you have hope for him.

8. **Report the information you have gathered immediately.** The risk should not be ignored and an evaluation should be made by a professional.

9. **If the risk is immediate, don't leave the person alone.** Suicide precautions established for your facility should be initiated.

10. **Reduce environmental hazards.** Get rid of sharp instruments, keep the resident away from windows and open stairs, etc. When administering medications make sure they swallow the medicine so it may not be saved for possible overdose.

These are several ways of working with a resident who may be feeling suicidal. The purpose is to find out what the resident thinks and feels and to try to keep anything from happening. There may be times, however, when someone has already started to attempt suicide before you have any warning that there is a problem.

There is a chance that you might at some time find yourself in the middle of a "suicide crisis," when a resident is actually attempting to commit suicide, with no trained professionals close enough to be there right away. The following guidelines are meant to help you in that kind of situation.

1. **Remember that the resident is torn between wanting to live and wanting to die.** You want to start a spark of hope. This may be done by:

   Assuring the resident that you want to help;

   Suggesting other courses of action that may solve his problem or help him feel better;

   Offering hope;

   Demonstrating that you care.

2. **Be prepared for the chance that he may still kill himself**. It may be too late to help. All you can do is try to stop what is already happening.

3. **Stay Calm.** Don't be judgmental or angry even if you feel scared or angry. Do not challenge the resident to do it. Trying to get the person to change his mind by saying that suicide is a cowardly thing to do or that the person is being selfish and inconsiderate of those who care is a dangerous course of action. Do encourage him to think of positive things in his life or people he cares about who would miss him and grieve over his death.

4. **Don't be in a hurry.** The longer you can talk with the person, the better your chances of finally getting him to change his mind. Do:

   Approach the resident calmly and carefully;

   Introduce yourself, say you want to help;

   Ask questions (Can't we talk about this? How do you feel? Have you thoughts of other solutions to your problem?)

5. **Offer Advice.** Suggest another course of action. Emphasize that people care. Also:

   Suggest that counseling is available to help;

   Suggest that a specific plan can be worked out for overcoming the problems;

   Offer to get a friend or relative who the person might want to talk with.

6. **Don't make promises that you can't keep.** Sometimes a desperate person will demand unrealistic promises, saying, for example, "If I don't do it, can you guarantee that I'll get help and won't be depressed any more?" In such cases, say, "I'm sure help can be found; of course stopping the depression will take time and work on your part, even with help."

7. **After considerable talking, if the person is calm and under control, suggest that he reconsider what he is doing and discontinue the plan.** If he gets excited, again start talking about the availability of help, other courses of action, etc.

8. **Upon arrival of person experienced in working with suicidal situations:**

   Introduce the individual;

   State that he wants to help;

   Let him take over;

   Stand by to assist.

In summary, some important points to remember when working with a suicide crisis are:

1. Keep calm.
2. Don't be judgmental.
3. Introduce yourself, say you want to help.
4. Offer to get a friend or relative.
5. Suggest other courses of action.

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SECTION C

INTERVENTIONS

CONTENT:

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DEPRESSION
INTERVENTIONS

BACKGROUND INFORMATION:

The treatment of depression is many faceted and heavily dependant upon the causes of depression itself. If the depression has a physical basis, the appropriate response is to treat the physical problem. Likewise, if depression is a side effect of a particular medication, perhaps an alternative or additional medication may be prescribed to relieve that adverse condition. Should the depression appear to stem from a chemical imbalance in the brain, medication therapy might be the treatment of choice. If an individual is reacting to changes and losses in his or her life, counseling may be the choice. Often a combination of factors may cause a depressive reaction and therefore, the treatment may involve several therapeutic interventions.

In this section Electroconvulsive therapy (ECT), Interpersonal Therapy and Environmental Therapy are considered.

Electroconvulsive Therapy

Electroconvulsive therapy, or ECT, is a treatment for depression that is used far less frequently today than it once was. It is used to treat depression that does not respond to other forms of therapy, specifically for the person who is at high risk for suicide. The process is also much safer and less traumatic than it once was. It is important to remember, however, that many of the older residents you care for may have very frightening memories of ECT treatments.

Basically, ECT is the passing of electric current through the brain causing a very temporary lapse in consciousness. After some initial confusion, the client awakes free from the feelings of depression. In many cases there is residual memory loss.

Interpersonal Therapy

Interpersonal therapy must accompany every other kind of therapy mentioned. It [illegible] that which takes place between the caregiver and the depressed resident. The basis of interpersonal therapy is acceptance of the resident as a valuable and worthwhile human being. This is at the core of all therapeutic interaction, and can be conveyed in both a verbal and non-verbal manner.

The caregiver must be a good observer and a sensitive listener. The goals of the communication may be varied according to the needs of a particular resident. A few generic goals should include the following:

a. Reinforcing healthy, active, and independent behavior;

b. Helping the resident feel important, necessary, and worthwhile;

c. Assisting him or her to feel hopeful about the future;

d. Supporting the resident as he or she mourns a loss;

e. Helping to reduce guilt and self-blame; and

f. Helping the resident to talk about underlying feelings.

Environmental Therapy

Environmental Therapy might be called part of a holistic approach to the treatment of depression. It is based on the principle that our behavior and our emotions are influenced, positively or negatively, by our environment. This is true for staff as well as residents in long term care facilities.

Many factors in an institutional environment influence attitudes and behaviors in the people who live and work there. Some of these facilities may be interested in doing a self-analysis to determine how their environment may project a depressive atmosphere.

MEDICATIONS AND THE ELDERLY

BACKGROUND INFORMATION:

Elderly people have several special circumstances to contend with when they take any kind of medication. Many persons, especially those in long-term care settings, have several health problems that require the use of multiple medications. At the same time, their bodies have undergone several changes as a result of the normal aging process. Many of these changes affect the way in which they distribute, metabolize, and excrete those medications. These factors together may significantly alter the therapeutic benefits of the medications they take. Further, the elderly resident may be more susceptible to the toxic effects of medications.

One of the ways in which a caregiver might recognize whether a medication is working is to observe the resident's behavior. All caregivers, whether or not they actually distribute the medication, should be aware of changes in the behavior of those for whom they care. Changes may be gradual or sudden. The behavior may resemble symptoms of other conditions such as depression or dementia. It is very important that these behaviors be reported to the charge person so that appropriate action might be taken.

The medications discussed in this manual are primarily psychotropic drugs, These are drugs that have an effect on mind function, behavior, or experience. When a psychotropic drug is given to an older person, it will usually take longer to work, will last longer in the body, and will produce a greater effect per milligram dose than in a younger person. In addition, elderly persons taking medications for physical conditions as well may experience an altered effect as the medications interact.

The caregiver must be the watch guard for the elderly resident taking medications. Often the side effects of these medications affect a person in such a way that they are unable to effectively articulate the problem. The caregiver becomes their voice and their advocate.

Medication Therapy

Anti-depressant medications work to correct neurochemical imbalances in the brain that can cause such symptoms as lethargy, mental slowness, sadness, despair and dejection. These drugs are only effective in situations where an imbalance of these chemicals occurs. For example, a depression caused by a reaction to external event alone would not respond to anti-depressant medication.

Many of the residents for whom you care may be taking these medications. As a caregiver who has daily contact with these people, you may be in the best position to observe the effects of those medications. Your observations are a critical part of determining the therapeutic value of these drugs. There are certain facts about these medications that you should be aware of as you care for your residents.

There are two major groups of anti-depressant medications: Tri-Cyclic and Monoamine Oxidase, or MAO, Inhibitors.

Tri-Cyclic Anti-Depressants

Electrical charges sent out by brain cells are called "neural impulses." The chemicals which convey these impulses to their destination are called "neural transmitters." Tri-cyclic anti-depressants affect neural transmitters. Some of the names of the brand names (and generic names) of these medications are Elavil (Amitriptyline), Tofranil (Imipramine), Norpramine (Desipramine), Aventyle (Nortriptyline), Sinequan (Doxepin), and Asendin (Amoxipine).

MAO Inhibitors

This group of anti-depressant medications also works by correcting a chemical imbalance in the brain, inhibiting the action on brain cells of a substance called monoamine oxidase. Some of the more common names (and generic names) of these medications are Nardil (Phenolyzine), Parnate (Tranylcypromine), and Marplan (Isocarboxiazid).

Both of these groups of medications have several common characteristics:

1. The therapeutic effects of these medications will probably take at least two weeks, more likely four or more, to be achieved. Because of the slow onset of action, both residents and staff may feel that the medication is not working. It may be necessary to remind the resident that while it may take time for the medication to work, it should help them to feel better. It is important to continue with the medication as prescribed.

2. Anti-depressant medications must be individually adjusted to achieve maximum benefit. Therefore, it is critically important for all staff to note changes in behavior (or lack thereof) as well as side effects and unwanted reactions. This information should be conveyed to the physician prescribing the medication. The physician prescribing the psychotropic medications must be informed of any other medication, including over-the-counter drugs, that the resident is taking.

3. Suicide is always a risk factor in depression. It is important to remember that the potential for suicide does not end when the medication begins to work. This may, in fact, be a more dangerous time as the new energy the resident feels may be channeled to complete an act once only thought about. Also, make sure medications administered by mouth are swallowed, not saved or stored by resident for possible suicide attempt.

4. Sedation at the initiation of therapy is a common occurrence, especially with older persons. Some have described the

feeling as similar to taking a sleeping pill and then having to carry out your activities under its influence. Caregivers need to use appropriate interventions to assure resident comfort and safety during this time. The sedative effect gradually wears off as the body adjusts to the medication, usually in a few weeks time. Some anti-depressant medications have less sedative effects than others.

5. The most common side effects experienced by people, especially elderly persons, using these medications are: urinary retention, dry mouth, constipation, blurred vision, and orthostatic hypotension. Cardiovascular side effects, such as orthostatic hypotension, tachycardia, and arrhythmias, may be more hazardous to older patients especially if they suffer from heart disease. All side effects should be reported to those responsible for medication distribution so that an individual assessment can be made. Side effects can and do compromise comfort and safety. It is the charge of the caregiver to provide the interventions to assure the greatest comfort and safety for their clients.

The above information applies to both the tri-cyclics and the MAO inhibitors equally. The MAO inhibitors have additional side effects which are unique to them. Specific dietary restrictions must be obeyed. Persons taking these medications must avoid goods that contain tyramine, including cheese, pickled herring, chicken liver, yeast, beer, red wines, cream, chocolate, broad-beans and pods. Also, no over-the-counter medications should be taken without the physician's approval. This medication may interact with the above foods and medications to cause a hypertensive crisis that is potentially fatal. In addition, this medication must have cleared the system before another antidepressant is started, as it may also trigger the same hypertensive response.

Lithium

Lithium is used primarily to control the dramatic mood swings of the person with a bi-polar affective disorder (manic-depressive illness). It works as a mood stabilizer. The toxic, or dangerous, levels of lithium are very close to the therapeutic levels. Dosage must be individualized and checked regularly by blood tests. The caregiver must be familiar with the toxic symptoms: persistent diarrhea, nausea, vomiting, drowsiness, slurred speech, dizziness, black-out, slowness of movement, muscle weakness, muscle hyper-irritability, and hypotension. Any of these symptoms should be reported immediately. Staff should also note any changes in the resident's behavior that may indicate he or she is becoming more ill, e.g., increase in activity, in volume and rate of speech, and in complaints from other residents.

Other Medications

Other drugs may be used either separately or in a combined pill form with the anti-depressants to relieve various symptoms. These are usually stimulants or tranquilizers. Ritalin is occasionally used with some depressed clients to improve function. Tranquilizers may be used with the client who is very anxious or agitated.

EXERCISE #1

INTERPERSONAL

THERAPY

OBJECTIVE:

To assist participants in identifying concrete ways in which they can help a resident who is depressed.

METHOD:

Six goals of therapeutic interaction (attached) are listed on a flip chart or blackboard. Participants work in groups of 4-6 to discuss specific actions that they might take regarding each of the goals. One member of the group should record the suggestions. Small groups report their interventions once the full group reconvenes.

DISCUSSION:

Participants will generally develop very creative lists on their own. The facilitator may use the accompanying list of interventions if desired.

TIME: 30 min.

GOALS OF INTERVENTIONS

#1 Reinforce healthy, active, and independent behavior

- Praise accomplishments, even small ones.
- Praise should be genuine.
- Encourage decision making if the resident is able.

#2 Help the resident feel important, necessary, and worthwhile

- Seek out legitimate things that the resident might do to assist others
- Accept the gift of love from the residents.
- Take opportunities to spend time with the resident, even if it is only five minutes. Make the time you spend exclusively their time.

#3 Assist them to feel hopeful about the future

- Avoid remarks like "Cheer up" or "It's all in your head".
- You can tell him that the depression will get better.
- Make concrete suggestions of what can be done, as long as they are small things that really can be accomplished. For example, if a resident doesn't want to wash his or her hair, at least encourage him or her to comb it.

#4 Support the resident as he or she mourns a loss

- Encourage the residents to talk if they want.
- Listen without judging the value of their loss.
- Ask how they coped with loss in the past. Remind them that they were able to cope.

#5 Help reduce guilt and self-blame

- Listen as residents tell you their feelings.
- Encourage them not to dwell on these feelings.
- Explore other ways of looking at the situation.

#6 Help the resident talk about underlying feelings

- Make time to give the resident your undivided attention.
- Be patient as it may take a long time for feelings to be identified and spoken.
- Share your observations about how the resident seems to you, e.g., you seem a little sad today.

EXERCISE #2

CASE STUDY

OBJECTIVE:

To discuss the most common diagnoses of depressed behavior as they relate to specific clients.

METHOD:

Participants are divided into groups of 4 to 6. The list of twelve problems (attached) should be printed on a flip chart or blackboard. Participants are advised that these are the twelve most common diagnoses relating to depressed behavior. After the group has had the opportunity to review the problems they are asked to consider residents for whom they care and who may be exhibiting several of these behaviors.

Each group has a recorder. Participants list all of the behaviors that they have observed. Participants are asked to discuss what they have done to intervene in problem situations.

DISCUSSION:

The trainer may use the attached Suggested Interventions sheet as a step off point for discussion. In most cases the participants have many excellent suggestions that have been successful. This exercise offers an opportunity to share the successes as well as the approaches that did not work.

This exercise offers an opportunity to share the observation they have made, each from his or her own perspective. The housekeeper sees the resident from a different point of view than the activities director. The night nurse sees a different person than the day nurse. By sharing the differing perceptions, a more detailed picture of the resident emerges. Specific interventions that have been identified as helpful now have the chance of being used more consistently by the whole team. Often new ideas for working with the resident emerge.

A final point can be made regarding the benefit of this kind of case study for developing realistic and therapeutic care plans.

Note: The importance of confidentiality in conducting this type of study should be stressed to all participants.

TIME: 25 - 30 min.

EXERCISE #2 - CASE STUDY

PROBLEM LIST

1. Feelings of sadness, despair, emptiness
2. Feelings of failure
3. Feelings of worthlessness
4. Feelings of being unloved, uncared for, and guilty
5. Retarded physical activity/withdrawal
6. Difficulty dealing with angry feelings
7. Inability to make decisions
8. Slowed thought process
9. Nausea, loss of appetite, refusal to eat
10. Constipation
11. Sleep disorders
12. Suicide

EXERCISE #2 - CASE STUDY
PROBLEM LIST
SUGGESTED INTERVENTIONS

Prob # **Intervention**

1. Provide non-threatening companionship on each shift, preferably the same staff persons. If the resident speaks, listen to understand. Listen for words that indicate feelings.

2. Move at the resident's pace. Enlist him or her in activities where success is assured. Begin with 1:1 activities, then 1:2, finally 1: group. Maintain a schedule. Let the resident know the time of activities when you will come to get him or her.

3. Persist in forming a relationship. Stop by several times during the day. Be consistent, keep promises. Sit and accept quiet behavior. Do not offer hallow words of encouragement, e.g.,"Cheer up, things will seem better tomorrow."

4. Make time for brief, non-essential encounters.

5. Move at the resident's pace. Be alert for any signs of wanting contact with others. Don't give in to withdrawal. Be aware of your own feelings of rejection or failure. Some medications which cause drowsiness can be given at bed time rather than during the day.

6. Listen. Also, diversional activities, especially physical ones provide an outlet for energy. Expression of feeling proceeds slowly. Accept the feelings of anger when they are expressed.

7. Use judgment. Do not ask resident to make even small decisions until they are ready. Provide a schedule, including even small activities. As depression subsides, encourage decision making.

8. Give only brief explanations about care. Speak slowly and clearly. Remain calm and pleasant.

9. Observe eating habits. Stay with the person during meals when possible. Offer less nauseating foods, e.g., fruit rather than fried foods. Try to learn from resident, friends or family what his or her favorite foods are.

10. Report your observations promptly and accurately. Work with the entire health care team. Be alert to behavior changes, report any changes in mood.

11. Observe and record sleep habits. Use back rubs, warm milk, warm showers or baths, sitting by the bedside as comfort measures. Check frequently throughout the night.

12. Suicide interventions are considered in detail in part 2 of this unit.

EXERCISE #3

ENVIRONMENTAL

ASSESSMENT TOOL

OBJECTIVE:

To provide an opportunity for facilities to complete an analysis of the environment in which its residents live and staff work in order to determine in what ways the environment may foster a depressive atmosphere.

METHOD:

The accompanying questionnaire may be used, followed by group discussion. The facility should decide who will participate in the assessment (staff, administration, residents, volunteers, family members,physicians, etc).

TIME: Varied

Note: Facilitation of the discussion process requires skilled group work, in addition to the willingness of the facility to hear and, if possible, act on some of the suggestions.

EXERCISE #3

ENVIRONMENTAL ASSESSMENT

QUESTIONNAIRE

A. **Physical Environment**

- * What is the color scheme in the day rooms, halls, bed rooms?
- * How are the beds arranged?
- * What are the seating arrangements in the community areas?
- * Is the dining area a pleasant place to eat?
- * Is music used in the facility at all?
- * How are meals served?
- * What do the outside grounds look like?
- * Are they accessible to area residents and staff?

B. **Social Environment**

- * Do activities encourage stimulation of various abilities and interests?
- * Do residents have a voice in deciding activities?
- * Are opportunities provided for residents to interact with the community in which the home exists?
- * Are residents provided opportunities to enhance self-esteem through social activities?
- * Are staff provided opportunities and time to support residents and in self-growth?

C. **Medical Environment**

- * Does the medical staff encourage rehabilitation and maintenance of function as well as control of symptoms?
- * Are support staff recognized for their contributions to the care of the resident?
- * Are direct caregivers involved in care plan meetings?

D. Interpersonal Environment

- * How would you describe the quality of interaction between staff and residents?

  Between staff members?
  Between staff and administration?
  Between staff and physicians?

- * Is there a vehicle for grievances, both residents and staff, to be heard?
- * Is communication on an adult-to-adult mode?

E. Administrative Environment

- * Do policies and procedures for resident care reflect a philosophy of maintaining and improving functional ability, rather than custodial care?
- * Do staff have necessary equipment and supplies to carry out their tasks?

Adapted from: **Residential Health Care Facility Training Project**, Rose DeBorj, Project Director.

HANDOUT #1

CAREGIVER

INTERVENTION

The caregiver should observe the following in patients receiving antidepressants:

* Changes in mood while drug takes effect

* Bowel and bladder elimination

* Intake and output

* Daily vital signs

* Dry mouth (use mints, gum or ice chips to alleviate/Mouth care may be necessary)

* Jaundice

* Headaches, sore throat, fever, and malaise

* Suicidal ideations

* Dizziness or complaints of feeling faint

* Irregular heartbeat (when checking for pulse)

* Increased appetite for sweets

* Slow pulse

HANDOUT #2

FOR THE CAREGIVER

Caring for a depressed resident is a very real challenge for the caregiving staff. The hopeless and discouraging attitude of a depressed individual can, at times, seem contagious to other residents and staff who already have concerns and worries of their own. In addition, the caregiver must always bear in mind the possibility of the resident becoming suicidal as feelings of hopelessness and helplessness grow.

While you are relaying information to other staff about your residents so that they can consider changes in medication and other kinds of treatment, it is important for you to realize that your every day interactions with a depressed resident will make a big difference in that person's getting well again. Yet, you cannot continue to care for others if you don't care for yourself as well.

Consider the following:

1. You are not personally responsible for the resident's total health and happiness. Do what you can, but understand that there are many other things which will make the difference in whether the resident gets over his or her depression.

2. Recognize that your personal energy varies from day to day. There may be days when you are better able to cope with the demands facing you. On the days that your energy level is low, enlist the help of your co-workers in facing some of the emotional demands. Don't be afraid to ask for help.

3. Keep in mind that the rejection you may be experiencing from the depressed resident as you try to help is not directed to you personally. This is not easy to do as rejection of what we give feels like rejection of ourselves. The tendency is for caregivers to withdraw when faced with rejection. While this is understandable, it has a negative effect on the resident. It reinforces their belief that they are unworthy of attention and may result in further withdrawal. Try to remember that rejection and unresponsiveness are often part of the illness of depression. They are symptoms as real as insomnia or loss of appetite. When you are feeling resentful and frustrated over a seeming lack of progress, talk over your feelings with co-workers or your supervisor. And, likewise, be there for others who may be experiencing similar feelings.

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UNIT #3

DEPRESSION

OUTLINE OF EXERCISES

OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION A:			
To identify the most common signs and symptoms of depressive behavior among the elderly	Exercise #1 Behaviors Common among Depressed Residents	Group Discussion	10-15 minutes
To identify and discuss the range of feelings most common among elderly residents who are suffering from depression	Exercise #2 Symtoms of Depression	Group Discussion	10-15 minutes
SECTION B:			
To identify the risk factors associated with suicide among elderly people	Exercise #1 Attitudes about Suicide	Small Group Discussion	10-15 minutes
To identify care-giver interventions for residents who are at risk	Exercise #2 "The Jumper"	Case Study & Small Group Discussion	10-15 minutes
	Exercise #3 Helping Strategies	Group Activity & Discussion	10-15 minutes

UNIT #3

DEPRESSION (CONT)

OUTLINE OF EXERCISES

OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION C:			
To review therapeutic interventions for residents who are depressed	Exercise #1 Interpersonal Therapy	Group Activity and Discussion with Accompanying Handout	25-30 minutes
To discuss antidepressant medications and their side effects	Exercise #2 Case Study	Group Activity & Discussion	15-20 minutes
	Exercise #3 Environmental Assessment	Questionnaire Regarding Facility Environment	Unspecified

UNIT #4

UNDERSTANDING

DYSFUNCTIONAL BEHAVIOR

UNIT #4

UNDERSTANDING

DYSFUNCTIONAL BEHAVIOR

Unit #4 examines types of behavior that are broadly defined as dysfunctional. Dysfunctional behaviors are those which occur when coping mechanisms, whatever they might be, do not protect us from accompanying assaults on the mind. The painful and irrational anxiety, often accompanied by sadness or terror, interferes with adjustment to life. This kind of dysfunctional behavior is often seen among boarding and nursing home residents as they try to carry out their daily activities.

There are many causes of dysfunctional behavior. In this unit we will examine the most common ones that occur among elderly people living in long-term care facilities. Emphasis is placed on recognizing the relationship between feelings and behavior and discussing appropriate interventions.

Section A reviews the basic defense mechanisms we use to cope with change and stress and examines how those same tools, when over or under-utilized, can promote dysfunctional behavior. Section B addresses psychotic behavior as a significant type of dysfunctional behavior. Late life paranoia, caregiving interventions and medication therapy are included in the discussion. Section C reviews generic approaches to working with the resident whose behavior is dysfunctional.

OBJECTIVES:

Section A To assist participants in recognizing the more common defense mechanisms used by residents experiencing episodes of anxiety.

Section B To identify the signs and symptoms of psychotic behavior.

To identify signs and symptoms of late life paranoia.

To review basic interpersonal interventions that are helpful in working with the client who is exhibiting dysfunctional behavior.

To review medications useful in treating dysfunctional behavior (including side effects) and other caregiving interventions.

Section C To reinforce the importance of developing a therapeutic relationship with those for whom care is given.

To explore the relationship between caregivers' own behavioral responses to clients' behaviors and their own potential for de-escalating crises.

To discuss the basic principles of working with violent behavior.

To review the importance of the "Post Incident" Conference.

CONTENT:

SECTION A - Defense Mechanisms ....pp. 1-12

SECTION B - Psychotic and Other Dysfunctional Behavior .....pp. 13-45

SECTION C - Behavioral Management...................pp. 46-60

REFERENCES..pg. 61

SECTION A

DEFENSE MECHANISMS

CONTENT:

Background Information - Defense Mechanisms ....pp. 2-3
Exercise #1 - Defense Mechanisms........... ....pp. 4-6
Handout #1 - Defense Mechanisms.....................pp. 7-12

DEFENSE MECHANISMS

Background Information:

The environment in an institution represents, at least on the surface, a community. It may consist of some buildings, a road, support services, perhaps a gift shop and certainly some common needs. Yet in other ways an institution is anything but a normal community. Inhabitants are rarely there by choice. They are there either by force or because of some perceived deficit on their part. Thus an institution represents a community, but a skewed one.

Forced togetherness, whether in a family or community, will always bring out avoidance or escape responses. These responses translate into behaviors that can be both frightening and frustrating to staff in health care facilities. As we begin this unit, it is important to note the major source of behavioral problems are stress and anxiety. In this section we want to consider some of the common ways of coping with stress and note that there are both healthy or adaptive methods that can help us, or unhealthy (maladaptive) ways of coping that can create even more difficulty.

The most common stress reactions affect the following areas of our lives:

Physical	Faster heart beat, increased breathing, higher blood pressure, upset stomach, and tense muscles. Continued stress can lead to such serious physical disorders as ulcers, heart conditions and hypertension.
Emotional	Insomnia, increased anxiety, panic, feelings of hopelessness, emotional outbursts.
Mental	Inability to concentrate, impaired memory, depression, obsessive-compulsive behavior, psychosis.
Self Destructive Habits	Overeating, drugs and alcohol abuse.

Most of us are familiar with the term "fight or flight." While these terms represent a variety of responses, they do describe the basic choices that we each have when confronted with a difficult problem. It is like being challenged by the town bully in the presence of school chums. You may be angry, frightened, humiliated and perplexed all at the same time. You have some quick assessing to do. If he isn't too much bigger than you, and maybe just a bit slower, you might throw caution to the wind and fight. If, on the other hand, your efforts would be like a BB hitting a tank, the better part of wisdom would be to run (flight).

Most of us have developed a balanced use of fight or flight as we have coped with life experiences. Some, however, have misused or overused these mechanisms with negative results in their lives. If for instance, a person used flight all of the time (ran from everything), what would be the result? This style of coping might, in all probability, lead to alcohol or drug use, which are also escape mechanisms. The overuse of the fight mechanism, on the other hand, could lead to violent aggression and rage, thereby reaping the consequences inherent in that life-style.

It is not always appropriate or possible to use fight or flight as a way of coping with stress. We may have, for instance, a long-term illness that we can neither run from nor fight against. We are all getting older and there is no way of turning back the hands of time. We each have inner struggles with our fears, our limitations, or our guilt. The truth is that stress would overwhelm us early in life were it not for mental defense mechanisms which we all have to help us maintain emotional balance. However, excessive or inappropriate use of these mechanisms can make them a destructive force within the individual.

For example, there is a defense mechanism called "conversion." In this mechanism, stress, so painful and powerful that it cannot be tolerated by the ego, is transferred (converted) into physical pain or symptoms. Many who have observed children growing up have probably witnessed the adaptive use of this mechanism. The following scenario will serve as an example.

A twelve year olds' little league team has made the play-offs. It is the top of the ninth inning and the score is tied. There are two outs and a man on third base. The young man has had two painful strikes. His teammates are cheering him on; it all depends on him. He swings desperately at the next pitch and misses. Missing the ball, the young man falls to the ground, grabs his foot and begins to cry. His teammates, concerned, gather around and the coach helps him to the bench and tells him "nice try." The dark moment has passed, he feels better and ready to play some more.

Was his foot really hurt or was the anxiety from the thought that he would fail his team and possibly lose the game simply more than his ego could tolerate? He hadn't planned to fall and hurt his foot, it just happened. But it did work for him. He was able to thwart the blow against his ego. Now what would happen if he began to use this all of the time, and it became a way of coping in his life? The end result might be seen in the resident who considers her visit to the doctor a painful intrusion of her self-esteem. Without fail, just before each scheduled doctors appointment she feels faint and has chest pains. The excessive reliance on this coping mechanism has so distorted her sense of reality that the faintness and pain have become real.

People therefore expend tremendous energy to protect their identity. In a very real sense, when the identity is destroyed, the person is destroyed. Institutional life, by its very nature, provides a constant threat to the identity. Thus, much of the behavior that caregivers must deal with is the result of defense mechanisms being used by residents to protect themselves against emotional pain.

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EXERCISE #1

DEFENSE MECHANISMS

OBJECTIVE:

To help participants identify common defense mechanisms used by residents to cope with stress and anxiety.

METHOD:

After handing out the attached "Matching sheet", the instructor asks participants, either individually or in small groups, to match the defense mechanism with the proper example. Participants are also asked to list the names of residents who they believe are using some of the defenses that are listed.

DISCUSSION:

On the attached discussion sheet (page 6), defense mechanisms are listed in the correct order to correspond with the examples listed on the matching sheet.

Discussions should be conducted in the context of the material listed on the discussion sheet as well as those residents who have been identified by the staff as using one of the defenses.

The instructor might encourage the participants to explore reasons why the resident might be using defenses. Are there ways in which the staff might better address the needs of the resident?

TIME: 15 - 20 minutes

EXERCISE #1 - DEFENSE MECHANISMS

MATCHING SHEET

RIGIDITY

PROJECTION

REACTION FORMATION

DISPLACEMENT

DENIAL

"I don't feel that way, you feel that way." The 75 year old former nurse feels envy and jealousy toward the younger nurses who are caring for her. She cannot accept these feelings as those thoughts are unacceptable to her ego. Therefore she projects those feelings toward the staff, accusing them of envy and jealousy towards her.

"Get out of my room, I can never depend on you nurses."

The old man was devastated because his son had said that he would come by on Saturday. Like so many other weekends, he just never showed up. He could have at least called. The elderly resident is both hurt and angry yet he could never express those feelings toward his son (he might never come again), so he must find a safer way in which to vent his anger. Consequently, he expresses his anger toward the staff.

"You don't have control over my whole life, I can choose what I want to do."

The nurses has no luck in trying to get Mrs. Smith to wear her new sweater. She insists on wearing the old one. She will not participate in social activities but in the day room she guards "her" chair with vengeance.

"No, I said! I'm not going to be here long enough to get involved in social activities".

Even though Mr. Rollins has been unable to live independently for years, he insists that there is nothing wrong with him. As soon as "they" realize that none of those incidents were his fault he will be leaving the boarding home. So why get involved?

"Am I being a good resident? You nurses are so wonderful. Come, let me give you a big hug."

Mary seems to have no will of her own. She won't do anything for herself. She is affectionate toward the caregivers to the point of being "sickeningly" sweet.

EXERCISE #1 - DEFENSE MECHANISMS

DISCUSSION SHEET

PROJECTION

This is a defense mechanism whereby unacceptable behaviors, such as jealousy, fear, suspicion, and anger, are projected outwardly toward someone else. Residents who suffer from hearing loss are prime victims to this coping strategy. Hearing losses which remain unaddressed often lead to feeling paranoia. Paranoid patients tend to overuse this defense mechanism.

DISPLACEMENT

In this defense mechanism, strong emotional feelings, (very often anger) that are felt toward one idea, person, or object are redirected to another. This mechanism is important for those in the health care field to understand. Nurses and aids often find themselves the objects of displaced anger from residents trying to cope with the stress of institutional living. Many parents have no doubt witnessed their children use this mechanism when, after being punished, go out and slam the door, hit the wall or kick the family pet.

RIGIDITY

In this mechanism a resident may develop a fixed, inflexible daily routine. This structure helps to counteract anxiety and gives the resident a sense of control over his or her life.

DENIAL

This is a defense which distorts reality so that real threats are negated. It is used to avoid or hide the existence of defects, dangers and illnesses. Denial has been called, "the foremost defense of psychosis."

REACTION FORMATION

In this mechanism an individual assumes attitudes, motives, or needs which are the exact opposite of those actually felt, but not acceptable to the ego. When someone is using this mechanism there is always an exaggerated quality to the behavior. For instance, a person may not only be nice but may be overly so. Residents often conform to the image of the "perfect" resident and will tend to do less and less for themselves.

HANDOUT #1

DEFENSE MECHANISMS

Mechanism/ Definition	Interpretation	Examples
1. Compensation A mechanism by which the individual seeks to make up for or offset deficiencies, either real or imagined.	It is a disguising mechanism involving an attempt to meet self-imposed standards, thereby preserving self-respect. It is a means of overcoming failure or frustration in some sphere of activity by over-emphasizing another.	An undersized young man becomes a bantam weight prize fighter. An unattractive and unpopular girl cultivates her intellectual capabilities and is on the honor roll in school.
2. Conversion A mechanism through which elements of intrapsychic conflict are disguised and expressed symbolically through physical symptoms.	Used to rechannel and externalize unbearable feelings.	A young mother, when told she was having twins, becomes blind. Mr. Jones develops laryngitis the evening before he is scheduled to give a speech at a business lunch.
3. Denial A mechanism by which the ego refuses to perceive or face emotional conflict.	It is an escape mechanism which allows the individual to move away from the unpleasant reality as if it did not exist.	A patient with a cerebral vascular accident refuses to attend physical therapy saying, "There's nothing wrong, all I need is rest." A comment often heard from patients in a psychiatric hospital unit: "I don't need to talk with you.

Mechanism/ Definition	Interpretation	Examples
4. Displacement A mechanism through which emotional feeling is transferred, deflected and redirected from one idea, person or object to another.	It is a disguising mechanism which uses a convenient, less threatening target to release emotional drives.	The boss berates Mr. Smith for a mistake. That evening he yells at his wife. Jane does not make the cheerleading team at school, and when she comes home tears down all of the football posters in her room.
5. Disassociation A mechanism through which the affective emotional significance is separated and detached from an idea, situation, object or relationship.	Its use allows the individual to isolate or compartmentalize painful feelings.	Jim grins and smiles as he relates the details about his car accident. Some clinical examples include sleep walking, traumatic amnesia or fugue states.
6. Identification A mechanism by which an individual patterns himself to resemble the personality and trait of an admired other.	It is a disguising mechanism used as an attempt to preserve the ego ideal. Its use contributes to ego development, but does not replace the person's own ego. Not exclusively linked with a decrease in anxiety.	An adolescent girl adopts the mannerisms and style or dress of a particular recording star. A young man chooses to become a draftsman just like his father.

Mechanism/ Definition	Interpretation	Examples
7. Introjection A mechanism through which loved or hated attitudes, wishes, ideals, values, objects or persons are symbolically incorporated into self.	It is a denying and disguising mechanism in which the ego structure is changed to keep the individual free from threat.	While playing, 5-year old Tommy says to his pal, Joey, "Don't get dirty, it's not nice." The painter who claims to be Jesus Christ.
8. Projection A mechanism through which the individual rejects aspects of self by imputing others' motives and emotional feelings which are unacceptable to self.	It is a refusal to acknowledge undesirable or instinctual impulses in order to protect the self.	Archie Bunker calls Edith a "ding bat". A secretary says, the girls in the office are jealous of her position and want to take over her job.
9. Rationalization A mechanization through which the ego justifies or attempts to modify otherwise unacceptable impulses, needs, feelings, behavior, and motives into ones which are consciously disowned.	It is a disguising and deceptive mechanism used to increase self-esteem and to obtain and retain social approval and acceptance.	Mrs. Ferris, who can't afford to buy a new dress says to friend Stella, "I'd love to have the dress in that window, but I don't think that the color suits me." While at a party, Mr. Peters says "I'll have one more drink. I don't have far to go."

Mechanism/ Definition	Interpretation	Examples
10. Reaction Formation A mechanism through which an individual assumes attitudes, motives, or needs which are opposite to consciously disowned ones.	It is a protective drive which serves to prevent the emergence of painful undesirable and unacceptable attitudes.	A young mother who is unaware of her hostile feelings toward her child becomes overprotective toward the child. Mr. Brown is extremely polite and courteous toward his mother-in-law, whom he intensely dislikes.
11. Regression A mechanism through which an individual retreats to an earlier and subjectively more comfortable level of adjustment.	It is a denying and protective mechanism which allows the individual to retreat from reality, reduce anxiety and become more independent.	A 4-year old begins to suck his thumb and wet his bed shortly after the birth of a sibling. Doris, 18, flies into a temper tantrum when she can't have her own way.
12. Repression A mechanism in which there is automatic and involuntary submerging of unpleasant or painful thoughts, feelings, and impulses into the unconscious.	It is the primary forgetting and protective mechanism used by the ego. All other mechanisms reinforce it. Repressed material is not subject to conscious recall.	Mr. Willis can't remember attempting to commit suicide. Mary, an unmarried, pregnant 20 year old, can't remember the name of the baby's father.

Mechanism/ Definition	Interpretation	Examples
13. Sublimation A mechanism through which instinctual drives which are consciously intolerable, or which are blocked and unattainable, are then directed into channels that are personally and socially acceptable.	It is the most efficient and creative of the defense mechanisms and serves to channel libidinal energy into constructive activities.	A man who has strong competitive or aggressive drives channels his energy into building up a successful business. A young unmarried woman derives satisfaction from taking care of neighborhood children.
14. Substitution A mechanism through which a goal, emotion, drive or need which is consciously unacceptable is replaced by one that is more acceptable.	It is a disguising mechanism used to reduce frustration and promote satisfaction.	A rejected boy friend "rushes" into marriage on the rebound. The dependence on the use of alcohol or drugs.
15. Suppression A mechanism through which there is a deliberate, intentional exclusion of thoughts, feelings, or experiences from the conscious mind.	It is a voluntary forgetting and postponing mechanism used to preserve the status quo and protect self-esteem.	Mr. Gordon carries the bills in his pocket before remembering to mail in the payments. During finals week, Lucy says, "I'll watch just one TV program before I study".

Mechanism/ Definition	Interpretation	Examples
16. Symbolization A mechanism through which an external object becomes an outward representation of an internal idea, wish, attitude or feeling.	It's a disguising, compensatory mechanism which is used as a vehicle for emotional self-expression.	Carey remarked to her friend. "you have a heart of gold." A boy sends his girl friend a dozen red roses.
17. Undoing A mechanism through which an individual endeavors to actually or symbolically erase a previous consciously intolerable action or experience.	It is a disguising and restoring mechanism to alleviate guilt and anxiety.	A mother who has just punished her child decides to bake cookies. A religious, single girl who engages in sexual activity with her boyfriend goes to church and lights candles.

SECTION B

PSYCHOTIC AND OTHER DYSFUNCTIONAL BEHAVIOR

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PSYCHOTIC BEHAVIOR

> "Reality, for the individual, is the world as that person perceives it, not necessarily as it exist."
>
> Mary Ardmore, 1976

Background Information:

Psychotic behavior is one kind of dysfunctional behavior. This behavior is characterized by the person's inability to "test reality" to the degree that it interferes with her day-to-day functioning. When a person is not able to test reality, she has great difficulty in separating what exists in her environment from what exists in her mind. Inner thoughts mingle with what you and I see as the real world. At this time people may have great difficulty functioning and understanding what is going on in the world as we perceive it. One way to think about this is to recall a day dream that you have had. Perhaps you imagined that you had won the lottery. You may have fantasized about the sports car you would buy or the trip that you would take, or even what you might say to your boss. Eventually, you returned from your make believe world and recognized that you must get out of bed and off to work if you expect to pay the rent. The person who functions in a psychotic state cannot always return to reality. He or she cannot separate the fantasy of winning the lottery from the reality of having to go to work. He or she may firmly believe that he or she is rich and famous and need not labor with others. He or she may even act on these false beliefs as if they were reality.

Perhaps you have had the experience of thinking that you heard someone call your name. You turn to find that no one is there. You may have said to yourself "It must have been my imagination." A person experiencing this kind of psychotic event, called an auditory hallucination, will not only believe that people are talking, but will more than likely answer back (other characteristics of psychotic behavior will be described later on in this unit).

Who experiences psychotic episodes? There are several different circumstances in which this behavior occurs. Some of the residents in a long term care facility may have a diagnosis of schizophrenia or manic-depressive illness. Although these illnesses may have been life long, having a chronic mental illness does not mean that individuals are in a constant psychotic state. Often times individuals feel quite well for long periods. But having a chronic mental illness may well mean that they have experienced several psychotic episodes during their lives.

A psychotic episode may also occur for the first time in old age. As discussed in unit #2, people can experience many additional stressors as they age. Overwhelmed by losses and inadequate coping mechanisms, anxiety levels can climb to an intolerable degree. The psychotic episode that occurs for the first time in old age is often related to some overwhelming stressor, such as a move from home to a long-term care facility, major illness, or surgery, or loss of sight or hearing. The episode may diminish as the stressors are relieved.

Psychotic behavior may also be seen in persons who have suffered some physical damage to the brain, such as a stroke or a dementia. Occasionally, other temporary conditions, such as a toxic reaction to a medication, overuse of alcohol, high fever, or other metabolic disturbances can cause a temporary state called delirium, during which the person may exhibit some of the kinds of psychotic behaviors described.

There are some major characteristic behaviors that are associated with psychotic episodes. Your experiences with psychotic behaviors may include more than what has been described here. Never the less, you may recognize many of the descriptions that follow.

As you proceed, it is important to keep in mind that all behavior has meaning. At times the meaning may be very difficult to understand. Often, you will need to look beyond the words to the feelings behind them. This is especially true in case of psychoses. The words may not make sense to you, but the feelings, emotions, and body language will speak loudly.

EXERCISE #1

VISUALIZATION:

REALITY ORIENTATION

OBJECTIVE:

To increase participants' sensitivity to the experiences of a psychotic episode.

METHOD:

It is difficult for most of us to even begin to understanding the experience of a psychotic break with reality. Unlike depression, which most of us have experienced to some degree, a psychotic experience lies beyond the common ground most of us share. The visualization exercise we are about to try does not presume to equate a psychotic break. It is merely meant to offer an opportunity to gain a minimal insight into a frightening world experienced by some of the people for whom we care.

Close your eyes, if you will, and recall a night when you had a particularly frightening nightmare. You will probably remember that on awakening you lay motionless in your bed, overcome with fear. Your heart raced and your breathing came in shallow gasps. For those few frightening moments you were experiencing an inability to distinguish reality from your dream. Stop for a moment and try to relive that experience.

PAUSE

You will remember that after a few seconds, you began to orient yourself to your surroundings. You glance at your bedside stand and see the alarm clock. The glowing hands indicate three o'clock. It is dark outside the window; it must be three in the morning. Perhaps the refrigerator clicks on in the kitchen, a familiar sound. Perhaps Tabby is purring at your side. Calm begins to descend as you are able to test your reality and orient yourself. Finally, you recognize that you are safe in your home and your experience was only a dream.

PAUSE

Remember, now, what you initially felt when you awoke from your sleep. Imagine, if you will, being trapped in that feeling of fear and confusion for hours, days, and even weeks. That is only part of what it feels like to experience a psychotic break with reality.

DISCUSSION:

TIME: 15 - 20 minutes

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HANDOUT #1

COMMON CHARACTERISTICS OF PSYCHOTIC BEHAVIOR

HALLUCINATIONS

Hallucinations are sensory perceptions that a person experiences in the absence of any external stimulation. Hallucinations are associated with the five senses: hearing, sight, smell, touch, and taste. The most common are auditory hallucinations, hearing voices that are not there. You may suspect an auditory hallucination if you observe the following behaviors: a resident listening, perhaps looking puzzled, lip movements, talking out loud to no one that you can see, nodding and shaking of the head. The messages that these voices carry may be frightening, sad, or angry. It is important to observe the non-verbal behavior in order to understand the feelings.

Alcoholics experiencing Delirium Tremors, or DTs, often experience tactile, or touch, hallucinations. They may have the terrifying sensation of bugs crawling all over their body.

DELUSIONS

Delusions are firm, false beliefs about reality that persist despite the evidence to the contrary. Delusions are often present in late-life psychotic episodes (this is discussed in greater detail in the section on paranoia). Delusions can often be frightening to the resident. They often center around someone trying to harm or hurt them so they must live constantly on guard. Delusions are usually one of three types: grandeur, persecutory or reference.

Delusions of grandeur revolve around the person's belief that he or she is a famous person, for example, Teddy Roosevelt or Jesus Christ.

Delusions of persecution involve the belief that someone or something is out to harm or take something from the person.

Delusions of reference concern the idea that the person is being controlled by some force outside the body, such as the television or x-rays from outer space.

LOOSE ASSOCIATION

This term describes a thinking disorder. The person is unable to maintain a single focus or thought. He or she skips from one unrelated thought to another, and feels that only he or she is making any sense.

DISTURBANCE OF AFFECT

The term "affect" means emotion. You may notice a resident showing an emotion that seems inconsistent with the situation. He or she may laugh at a situation that everyone else finds sad, or cry when everyone else is laughing. Sometimes there is no emotion shown at all. This is called a "flat affect."

DISTURBANCE IN PSYCHOMOTOR BEHAVIOR

This change is most noticeable to the caregiver. It may show itself as a decrease in spontaneous movement. The person may become very quiet and withdrawn. Conversely, the caregiver may notice that there is an increase in movement accompanied by agitated, purposeless pacing, grimacing, and bizarre mannerisms.

These characteristics of psychotic behavior may show themselves in various observable behaviors. Some of the following may be familiar to you as concrete behaviors that you have seen. You may well have other examples to add.

* Hearing voices
* Talking to people who are not there
* Garbled speech
* Speaking in unrelated thoughts
* Becoming suddenly hostile, without explanation, falsely accusing others of wrongdoing
* Holding strange beliefs about self and others that have no basis in fact
* Agitated pacing for no apparent reason
* Exaggerated or outlandish movements or gestures

Remember that emotional reactions of a dysfunctional proportion occur when usual defense mechanisms are no longer sufficient to reduce anxiety. In general, the resident who has experienced a psychotic episode needs support from the caregiving staff. Staff should provide a sense of calm, safety, and security in the environment.

Residents will react differently when the episode is over. All will need reassurance that staff care about and respect them. Some may not want to talk about their experiences; others will need a person to share with. The caregiver must take his or her cue from the resident. All opportunities to reinforce residents' sense of self-esteem must be employed.

Consistency in approach by staff is especially critical at this time. This is a confusing time for the resident and receiving mixed messages can increase stress further. Team involvement in care planning is essential.

AUDITORY

HALLUCINATIONS

Background Information:

It is difficult to fully understand auditory hallucinations unless they have been experienced. When auditory hallucinations are occurring, the person may experience problems concentrating on their external environment. The sounds heard are mistakenly thought to be real and coming from the environment. Individuals who are hallucinating are distracted by the voices that they are hearing. The voices heard can be God, the Devil, relatives or neighbors, or perhaps not be recognizable or understood. Two or more voices may be talking about the person hearing them. Sometimes, even their own thoughts, when reading or thinking, may be heard as voices. The person may have to listen very intently to understand what is being said. Voices interfere with daily activities and can lead to much frustration.

EXERCISE #2

AUDITORY

HALLUCINATIONS

OBJECTIVE:

To sensitize participants to the experience of an auditory hallucination.

METHOD:

Instructor can demonstrate auditory hallucinations in the following manner:

Have one participant sit and listen to a small radio or tape recorder, with a headset. A second participant will talk to the first while he/she is listening to the radio. The second could ask questions related to job, imaginary admission or converse about daily matters. The volume on the headset should be loud enough to distract the listener from the interviewer. Music or prerecorded messages can also be used.

As an alternative, three participants can do this exercise. The third participant should sit behind the "listener" and be the "voice," talking quietly (or whispering) into his/her ear. The second participant will do as instructed above. A prepared script can be used (or something the instructor feels is appropriate can be read). Participants need to be reminded that the person simulating the voice cannot be seen, and persons hearing the voice should not see the script prior to the exercise (a sample script for use with this exercise is attached).

Individual participants should be given their instructions separately.

DISCUSSION:

After this exercise has been completed, the instructor should allow time for discussion of the feelings experienced by all participants. Other participants observing may wish to share behaviors that they observed, such as nodding, restlessness, etc.

TIME: 20 - 25 minutes

SUPPLEMENTAL INSTRUCTIONS AND SAMPLE SCRIPT

The following questions are samples of those that can be used by the participant playing the role of "Interviewer." Other questions may be substituted as desired or as they are thought of. During the interview, this participant should feel free to add any comments that are appropriate to this situation, i.e., observed behaviors, of the participant playing the role of the hallucinating patient.

Interviewer:

Explain that you are the nurse and that you wish to ask a few questions:

1. Do you know where you are?

2. Who brought you here today?

3. Is there anything that I can get for you to make you more comfortable?

(At this point it would be appropriate to sit quietly and observe patient.)

4. How do you feel about being in a nursing home?

(Perhaps comment on how nice this person is dressed, some positive comment.)

5. Are you able to hear me alright?

SAMPLE SCRIPT

This script can be used for third participant playing the role of the "voice." Participant can use it as a guide and add whatever words they may think of during the exercise. It is important to keep in mind that this participant cannot be seen. Voices should be kept low enough to be heard, but not clearly understood. Participants should take time with words.

"You should not trust anyone (let voice fade to whisper). People will hurt you. Your family is plotting against you (silence, no sounds). This is a bad place (make just noises at this point, such as humming, clicking, etc.). You are dumb. You should not allow them to keep you here (again, silence). You are a good person, you do not need their help. You have worked hard. You should be allowed to .... Go home, go home, leave, what is the matter with you? Leave, leave............ Relax they will not hurt you. We like you, like you like..........."

EXERCISE #3

RESPONDING TO DELUSIONS AND HALLUCINATIONS

OBJECTIVE:

To identify therapeutic approaches to the resident who is delusional or hallucinatory.

METHOD:

This is a group discussion. Instructor asks members of the group if they have cared for residents who were delusional or hallucinating. Participants are asked to describe: 1.) the behavior observed; 2.) when the behavior occurred; 3.) what they did in the situation; and 4.) how their approach worked.

DISCUSSION:

The following points should be emphasized during the discussion. The trainer should use his/her judgement for when introduction of the following thoughts is appropriate.

1. Though the caregiver may know that the delusion and/or hallucination is not real, he or she must accept that these things seem very real to the person experiencing them.

2. Reassurance, both verbal and non-verbal, may be offered to the resident who may be feeling anxious, guilty, or afraid.

3. Do not support the delusion or hallucination, but also do not argue about whether it is real. An appropriate response might be, "I do not see the face, but I know that it seems real to you." Or, focus on the resident's feelings. "You seem very sad (frightened, angry, etc.)." Allow the opportunity for the resident to respond.

4. Provide a sense of calm, safety, and security in the environment. Show this in your tone of voice and in your body language. Support concrete reality when possible, reaffirming what is actually going on in the environment ("Your lunch will be here soon. Your food will help make you stronger.").

5. Keep track of what the delusions and hallucinations are about and when they seem to occur. Note any changes either in the quality or the timing of the behavior. Report these changes to your supervisor.

6. When possible, help the resident with "reality". Point out familiar objects and people. Be calm and reassuring.

7. Be wary of parts of the delusion or hallucination that might make the resident do something dangerous to himself or someone else. Take necessary precautions according to facility policy and report to charge person.

8. Tell the resident to tell you if the voices or ideas are getting worse. Assure that you or another staff person are there to help him/her.

TIME: 25 - 30 minutes

SCHIZOPHRENIA AS

DYSFUNCTIONAL BEHAVIOR

Background Information:

Schizophrenia is a severe mental illness described as a "group of behaviors that occur because of disordered thinking and an inability to relate to others. Disordered thinking involves thoughts that may wander or race, disconnected to one another. Words may not make sense and it is often difficult to follow or understand the content of the message being communicated. Made up words that have meaning only to the resident (neologisms) may be used. The person may be receiving mixed messages both from his own internal thoughts and from the external world. He may have great difficulty distinguishing these messages and meanings.

People with schizophrenia may also have difficulty identifying their own physical boundaries. There is a fear of losing their own identity through physical or emotional closeness to others. Hallucinations and delusions are often part of the illness (see pp. 22-23).

Behaviors seen in schizophrenia often reflect protective mechanisms against the real world in which the person is unable to cope, a response to environmental stress. The following behaviors are often observable among people with schizophrenia:

* Withdrawal and isolation
* Confusion in speech
* Incoherence
* Unrelated smiling, laughing, and giggling
* Avoidance of eye contact
* Schizophrenic stare
* Cold, blank stare
* Odd dress
* Watching T.V. with a cold, blank stare

The illness of schizophrenia may be easier to understand if we think about our own thoughts and behaviors. Behaviors such as simple activities of daily living require a certain amount of planning and scheduling. For many of us this involves other people. To plan and schedule we must think and communicate verbally and nonverbally. Much of it may not be conscious. For example, we get up in the morning and automatically go through our routines. If those routines are interrupted by a power failure or flat tire, we may be late for work. We must then make other arrangements, ask for help, call work, or fix the tire. We will perhaps feel a certain amount of stress and frustration and anger. Our anxiety level may go up, but hopefully we will use our healthy coping skills to adjust. Most of the time we are able to think logically and reduce our stress and anxiety and get on with our day. In the case of a person with schizophrenia, this example may be handled quite differently. The fear of being late could overwhelm the skills needed to change the tire. Inability to understand even that the tire needs changing can bring about such anxiety that the person might withdraw for the rest of the day.

In caring for someone who is exhibiting dysfunctional behaviors, it is important to monitor our own behaviors and feelings when we approach them. You, as a caregiver, are using yourself in a way that can be helpful in building a trusting, caring relationship. It is important to remember that even though a person suffering from schizophrenia may withdraw or isolate themselves from others and their environment, they are probably aware of all that is going on around them. They can be quite perceptive of non-verbal behavior and the feelings connected with that behavior. The opposite may also be true.

Caregiving interventions include:

- Giving emotional support and nurturing
- Sensitivity to their fear
- Moving slowly to establish trust and emotional closeness
- Making gradual contact, allowing them to get used to your presence
- Listening to verbal and nonverbal symbolic communication
- Allowing the person to proceed slowly, remembering they need the opportunity to sort out their thoughts
- Asking person to help you understand, never saying that you understand when you don't
- Always calling the person by name (this helps to increase his/her sense of identity)
- Slowly encouraging him/her to take part in activities

With treatment, the person with schizophrenia can begin to deal with the real world and experience it as others do. Medication can reduce anxiety and fear, thereby lessening disorganized thinking. Counseling may then be helpful in assisting the person to cope with stress and gain better self-understanding. Successful treatment can help reduce uncomfortable feelings related to interactions with others. Residents may withdraw less and the loneliness that results from isolation may be reduced.

LATE LIFE PARANOIA

Background Information:

Many older people without a previous history of mental illness may develop a paranoid approach to life. This may be characterized by suspiciousness and insecurity. There may be many different factors that contribute to late life paranoia. As older people begin to suffer multiple losses and feel they have lost control of their lives, some may cope with this anxiety with delusional behavior. The delusion may center around someone specific trying to take something from them, or harm them in some way. Often, the paranoid person has a history of suspiciousness, hostility, and isolation. They may have functioned quite independently in the community until life circumstances forced them into a long term care facility. The loss of privacy and ensuing dependency may contribute to the individual's delusional system. Sensory losses, which increase isolation and helplessness, may also contribute to paranoia. Paranoia associated with hearing loss is quite common.

It is also of interest to note that sometimes the beginning of paranoid feelings has its basis in reality. Cases have been found where someone was really plotting against the elderly person. Each situation needs to be assessed on an individual basis.

Many people live quite independently in the community, even though they may be having paranoid delusions. Problems usually arise when a change increases their anxiety to the point where a psychotic break with reality occurs. At the point where delusional behavior interferes with the person's daily functioning, intervention is needed. For example, a person may live quite well even with the delusion his neighbor wants to steal his money. The problem arises when the delusion expands to point that he believes the neighbor is poisoning his food in order to get to his money. He therefore decides he can no longer eat his food.

Caring for the person who is paranoid is a great challenge to staff. Paranoid residents are caught between the need for help from others and their fear and mistrust of human contact. The most commonly used (and overused) defense mechanism is projection. You will recall from section A that projection is the placing of one's own feelings or impulses onto another person or object. For example, the older person who feels useless and unnecessary will often unjustly accuse staff or family of rejecting them. It is not easy for staff to have to cope with these unfounded suspicions on a daily basis. However, as much as the caregiver may feel like arguing with the resident about his/her beliefs, this may only serve to convince the paranoid person that you are also plotting against him/her. Even with quality caregiving, it may be very difficult to see progress. Paranoia may lift slowly, if at all. The following handout will offer suggestions for working with the resident who is paranoid.

HANDOUT #2

CARING FOR THE RESIDENT WHO IS PARANOID

1. Since paranoid persons need to learn to trust themselves again, encourage the resident to function independently where success is likely. Provide opportunities for them to make decisions about daily life whenever possible.

2. Since persons with paranoia have difficulty trusting others, caregivers need to be very direct, concrete and up-front in their communications. Do not whisper to others in their presence and, while humor may be helpful in working with these residents, use care that they do not feel that you are laughing at them.

3. Be aware of changes in their environment and recognize the anxiety that may result from those changes.

4. The resident likes to know what is going to happen ahead of time. Let him know as soon as possible what will be taking place that day.

5. Make no casual promises to the person who is paranoid. Say only what you will actually do, and do what you say you will do. Rather than say "I'll see you later," say "I'll be back to see you before lunch," and then make sure that you follow-up.

6. Remember, sensory losses, especially losses in hearing, can increase paranoia. If the resident has a hearing problem, take the extra time to speak slowly and in a normal voice. Make sure that the resident can see your face.

7. If memory loss is another factor, this may also increase anxiety. Use reminders in the environment to help trigger memory.

8. Do not agree with residents about any delusions they may be having. When the larger reality is distorted, i.e. "The whole world is against me.", try to focus on the smaller reality ("Tell me what in this room makes you feel that way."). Arguing with the paranoid person will do little to change his/her version of reality, but may convince him/her that you are neither very bright nor trustworthy.

EXERCISE #4

VISUALIZATION:

PARANOIA

OBJECTIVE:

To sensitize participants to the experience of paranoia.

METHOD:

Participants are asked to recall the most frightening movie they have ever seen. The instructor may wish to use a movie that was especially frightening to him/her as an example. Recall that when you went to the movie you had certain expectations about what would happen, i.e., you would be frightened by the movie. In the early parts of the film, you might have been able to pick up some clues that something bad was going to happen, eg., things people said, the way they acted, and the events that took place. As the movie progressed, the clues became more pronounced, the tension mounted, the music built to a crescendo, and you were tense, anxious, and on the edge of your seat waiting for something to happen. Finally, it did and after the initial fright, the tension was released, at least until the next scene.

Imagine again the feelings that you experienced just before something happened. That will give you a little idea of what the paranoid person feels all of the time. They are in a constant state of alert, always waiting, always watching, for the worst to happen. Since much of the paranoia comes from delusional thinking, in reality usually nothing happens, only the constant and enduring apprehension.

DISCUSSION:

The trainer might ask participants to share experiences they have had with residents who are paranoid, or have some of the characteristics of paranoia. What delusions were present? How did the caregiver respond? What approaches were effective? Which ones were useless?

NOTE TO TRAINER:

A review of handout #2, Caring for the Paranoid Resident, may be helpful prior to this exercise

TIME: 15 - 20 minutes

EXERCISE #5

CASE STUDY: THE RESIDENT WHO IS PARANOID

OBJECTIVE:

To allow participants to discuss interventions for paranoid residents utilizing a case study.

METHOD:

Each participant is provided with a copy of the attached case description. After allowing ample time for reading and thought, the instructor begins a discussion using the following questions as a guide.

DISCUSSION:

1. What do you feel were the contributing factors to Ms. Everson's psychotic state in the hospital? (vision and hearing loss, loss of familiar surroundings and routine, no support system, forced interaction with many strangers)

2. What is the difference between her psychotic state in the hospital and her delusional state of mind at the home? (Though she believes that someone is taking things from her in the home, the delusion is not jeopardizing her well being. In the hospital, she is refusing to take necessary medication and refusing to eat her food. This cannot go on without serious consequences)

3. What kinds of emotions do you think Ms. Everson is trying to convey? What coping mechanism is she using? (She may be dealing with feelings of anxiety over all the losses she has sustained, loss of home,loss of sense of importance, loss of hearing, vision, loss of self-esteem. She is using the defense mechanism of Projection. She is projecting her own feelings of jealousy (of those more able than she) onto the aides.

EXERCISE #5

CASE STUDY

Ms. Everson is a new resident in your nursing/boarding home. She is 77 years old and, until recently, has lived alone in her own home. Recently she was hospitalized with a serious eye condition that left her with a vision loss serious enough to prevent her returning home at this time. For several years she has functioned with a hearing loss as well.

You have learned that Ms. Everson worked as a nurse all her life. She retired only a few years ago and had very little social life outside of work. Her family consists only of one niece who rarely visits. Ms. Everson never married. Her niece says that is because Ms. Everson was always too rigid in her lifestyle and had unrealistic expectations about people. Ms. Everson herself says "Men are not trustworthy and only want what you have."

While she was in the hospital, Ms. Everson became very anxious. She became convinced that the aides who were caring for her were jealous of her R.N. status. She refused to take her medication or eat her food, as she was convinced that the aides had poisoned them. Haldol was prescribed in an attempt to decrease this delusional state of mind. She did begin to eat and take her medications before leaving the hospital.

At your home, Ms. Everson remains distrustful, though she is still eating her food and taking her medications. She demonstrates her uneasiness by arranging her possessions in a very precise manner on her dresser. She says that she is sure someone is tampering with her things and stealing from her. In this way, she hopes to discover the truth. She interacts only minimally with other residents as she feels somewhat superior to them.

Adapted from: **Residential Health Care Facility Training Project**
Rose Dobrof, Director.

MEDICATION THERAPY

Background Information:

Psychotropic medication is used as one kind of intervention for those residents who are experiencing dysfunctional behavior if that behavior interferes with the person's ability to carry out daily activities. The most common medication prescribed for psychotic behaviors are called major tranquilizers. The following are their therapeutic effects: reduced anxiety, decreased delusions and hallucinations, decreased restlessness, agitation, aggression, sleep problems, and excessive movement.

Some persons in boarding and nursing homes who have experienced psychiatric illness all their lives may have been taking these medications for many years. Other residents may have this type of medication prescribed for the first time while they are in your care. In either case, it is essential that caregivers keep the following points in mind:

1. Medication is only a part of the whole therapeutic strategy. It cannot take the place of caring staff and therapeutic interpersonal skills.

2. All persons taking these very potent medications are subject to the side effects that they might cause. Those side effects may be more common during the first weeks and months of use, but they can occur at any time due to changes that take place as the body ages (see Unit #1).

3. Some of the side effects of these medications are irreversible in their late stages. Therefore, it is critical for caregivers to make accurate and timely assessments and report them appropriately. All facility staff should be familiar with the side effects present in tranquilizers even if they do not distribute medications themselves. The person more likely to observe these side effects is often the person who does the day-to-day, hands-on care.

4. The elderly are more susceptible to psychotropic drug toxicity and severe extrapyramidal side effects. These side effects can be very disabling and cause serious problems in a resident's daily life.

5. The medications may take longer to achieve the desired results, will likely remain longer in the body, and may ultimately produce a greater effect.

6. The greatest challenge to direct care staff is to watch residents closely and to be able to distinguish the differences between side effects and other problems the resident might be having.

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HANDOUT #3

CAUTIONS FOR ADMINISTERING PSYCHOTROPIC MEDICATIONS TO THE ELDERLY

A. Small doses are recommended, especially with the frail elderly.

  a. May be especially sensitive
  b. Fewest drugs possible should be prescribed

B. Should be taken with food or full glass of water or milk to reduce gastric irritation.

C. If measured with a dropper, dilute in half glass of tomato juice, milk or carbonated beverage.

D. Do not give within an hour of antacids or antidiarrheals.

E. Avoid getting liquid medications on skin. May cause rash.

F. Allow resident to rise slowly from a lying-sitting position to standing.

  a. Can cause a drop in B/P or orthostatic hypotension
  b. Resident may become dizzy, faint, or feel light-headed

G. May cause urine to turn reddish brown.

H. Medication decreases perspiration and body's ability to cool itself.

  a. Avoid overheating in exercise, hot water, and hot baths
  b. Protect from the sun

I. Drug interactions may occur.

  a. Almost all drugs have multiple effects and side effects
  b. Elderly persons may be particularly susceptible

J. Elderly are more susceptible to psychotic drug toxicity.

  a. Severe extrapyramidal side-effects from neuroleptics
  b. Usually these medications take longer to work
  c. Effects can last longer

K. Occasionally they can be less effective in usual doses.

ANTIPSYCHOTIC MEDICATIONS

AND SIDE EFFECTS

Background Information:

The side effects that may occur with anti-psychotic medications are known as extrapyramidal side effects. These can be very frightening to the person experiencing them and, possibly, to the caregiver who is unfamiliar with what is happening to his/her patient. For some patients, they can be uncomfortable, confusing and embarrassing. They can be controlled and treated fairly easily.

There are four general classes of EPS.

A. Parkinsonism: It resembles Parkinson's Disease in the shuffling gait, drooling, muscular rigidity, changes in posture, tremor, fatigue, and feelings of weakness. Residents may lose interest and feel slowed down. These feelings and behaviors could be confused with depression. A decrease in muscle strength may also occur.

a. these symptoms may be noticed within a week and before the end of the second month of treatment. They may subside with or without treatment, and the patient may adjust to these effects.

b. The drug-induced symptoms of parkinsonism are easily controlled by reducing the dose or changing the medication, or administration of antiparkinson medication.

B. Dyskinesias and Dystonias: Dyskinesias are coordinated, involuntary, stereotyped, rhythmic movements of the limbs and trunk. They are most common among men.

Dystonias are uncoordinated, bizarre, jerking or spastic movements of the neck, face, eyes, tongue, torso, arm, or leg muscles: backward rolling of the eyes in the sockets (oculogyric crisis); sideways twisting of the neck (torticollis); protrusion of the tongue; or spasms of the back muscles (opisthotonos). These symptoms occur suddenly and dramatically. They are often painful.

If these symptoms are severe they can lead to respiratory distress or difficulty in swallowing or talking. The patient may first become aware of them while eating. Without treatment, they will come and go and stop in about a week. If treated, they remit almost immediately and usually do not recur. Dystonias may occur anytime after giving the first dose of an antipsychotic medication and may last a few minutes to several hours.

These symptoms should be treated immediately and the patient assured that these are common side effects and that they will subside.

Akathisia: This is a feeling of restlessness and results in an inability to sit still. It should not be mistaken for agitation. The patient may complain of a twitching or crawling sensation in the muscles. They cannot resist the need to walk and shift from one position to another. They may sit and stand repeatedly and find it difficult to lie down or sleep. It also makes it difficult for them to read, watch television, or do handwork. Depending on the severity of the akathisia, the feelings may resemble sexual excitement, terror, fright, anger, or sometimes rage. It is important that the patient be told that these are side effects and not an emotional upset.

This side effect is first seen after about two weeks of treatment. It is more common in women and in middle age. The dosage of medication can be reduced or the medication changed to one with lower incidence of akathisia. An antiparkinsonian medication can be tried. Diazepam can be used also.

Tardive Dyskinesia: This group of side effects are the result of long-term use of anti-psychotic medications. It can be reversible if detected early. Patients receiving these medications should be screened at least every three months for signs. The earliest signs of TD are excessive blinking and fine, vermiform (worm-like) movements of the tongue. They progress and fluctuate until they interfere with daily activities. It becomes difficult to bathe, dress or eat. Grimacing, blinking and frowning may be noticed and the tongue may protrude.

Another behavior that may be seen is the piano-playing restlessness of the fingers. These symptoms can be controlled by the patient with intense voluntary effort and are absent during sleep.

These symptoms may also be hidden by anti-parkinson medications. Again screening is important in prevention of what can become a permanent complication of these medications.

Patients and families should be familiar with the risks that are involved with these medications. All staff should be aware of these behaviors described and alert others to changes that might indicate side effects are occurring. It is important to listen to the complaints of the resident that may indicate problems and report them. These patients need reassurance and support when taking these medications. Not all patients develop these side effects.

HANDOUT #4

ANTIPSYCHOTIC AGENTS IN THE ELDERLY

Differences in Side Effects Between Low Potency and High Potency Agents

GENERIC	**BRAND NAME**	**DOSE EQUIVALENCE**
Low Potency		
Chlorpromazine	Thorazine	50 mg.
Thioridazine	Mellaril	50 mg.
High Potency		
Fluphenazine	Prolixin	1 mg.
Haloperidol	Haldol	1 mg.
Thiothixene	Navane	2.5 mg.
Trifluroperazine	Stelazine	2.5 mg.
Perphenazine	Trilafon	.5 mg.
Loxapine Saccinate	Loxitane	7.5 mg.

LOW POTENCY, HIGH SEDATION & ANTICHOLINERGIC SIDE EFFECTS

HIGH POTENCY, EPS AND PARKINSONIAN SIDE EFFECTS

All cause Tardive Dyskinesia to the same extent

Source: Clinical Handbook of Antipsychotic Drug Therapy by Aaron Mason,M.D., and Robert Granacher, M.D.

HANDOUT #5

ANTIPSYCHOTIC

SIDE EFFECTS

Low Potency

Sedation

Hypotension

Dry Mouth

Blurry Vision

Constipation

Urinary Retention

Photosensitivity

Weight Gain

Slight EPS

Tardive Dyskinesia

High Potency

Stiffness

Restlessness

Tremor

Akasthisia

Cogwheeling Stiffness

Slight Sedation

Tardive Dyskinesia

Sexual Dysfunction

ANTIPARKINSONIAN

MEDICATIONS

Background Information:

Antiparkinson medications may need to be prescribed when a patient is receiving antipsychotic medications. Some physicians feel that they should be given to prevent the side effects; others may use them only if side effects occur.

It is recommended that low potency neuroleptics be used in low doses. Low doses of the high potency neuroleptics are preferable when possible to reduce the possibility of the extrapyramidal side effects. Long-term use of the antiparkinson medication is discouraged as it can aggravate the tardive dyskinesia that may be present. There is also the possibility of toxicity due to their anticholinergic side effects as listed on handout #5.

The dystonic side effects that may occur with the antipsychotics can be alarming, and treatment with an antiparkinson medication can bring relief. These medications help to reduce the bazaar movements of the tongue, face and neck that are seen with a dystonic reaction. These movements may disappear without treatment, but are usually treated, as they are often painful and psychologically upsetting to the patient.

The parkinsonian symptoms also respond to these medications. These symptoms can occur early and may persist. Possible signs of extrapyramidal side effects may be apathy, inability to participate in activities, lifeless, zombie-like or drowsy behavior. They should not be confused with emotional withdrawal.

Restlessness that is known as akathisia cannot be controlled by the patient and should not be confused with agitation. If the antipsychotic medication is increased to reduce agitation, the symptoms will become worse. Akathisia usually responds to treatment with antiparkinson medications or reduction of the dosage of the phenothiazine. Changing to another neuroleptic may also alleviate these symptoms.

The cumulative effect of other medications that have anticholinergic side effects must be considered in caring for elderly patients. They can be more susceptible to the side effects which include blurring vision, constipation, urinary retention, and dry mouth.

HANDOUT #6

SIDE EFFECTS OF ANTIPARKINSON AND MEDICATIONS

PSYCHIATRIC SIDE EFFECTS:

Confusion
Hallucinations-including visual
Incoherence
Disorientation
Restlessness
Agitation
Difficulty speaking
Delirium
Seizures
Delusion
Depression
Euphoria

PHYSICAL SIDE EFFECTS:

Dry mouth *
Blurred vision *
Sedation

Nausea
Muscle weakness
Difficulty swallowing
Dizziness
Headache
Warm dry skin
Tachycardia
Dilated pupils-slow to react
Fever
Urinary retention *
Constipation *

These side effects may also occur with the antipsychotic medications. It is very important to report any of the above signs or changes in behavior such as difficulty in swallowing and nausea. The emotional and mental changes must be observed, recorded, and reported as they may also indicate problems with side effects.

* considered to be major side effects

HANDOUT #7

ANTIPARKINSONIAN

DRUGS

DRUG a,b,c,	DAILY DOSE RANGE (mg) d
Anticholinergic Drugs	
Benztropine (Cogentin)	2 - 8
Biperiden (Akineton)	2 - 6
Trihexyphenidyl (Artane, Tremin)	6 - 20
Antihistamines	
Diphenhydramine (Benadryl)	25 - 100
Orphenadrine (Disipal, Norflex)	300
Dopamine Releasing	
Amantadine (Symmetrel)	100 - 300
Ethopropazine (parsidil)	50

a. With the exception of Amantadine, all of these drugs are strongly anticholinergic, and are commonly implicated in anticholinergic syndromes, especially if used in combination with thioridazine and/or heterocyclic antidepressants.

b. These agents are usually prescribed in divided doses, 2 or 3 times daily to achieve the total daily doses in the table.

c. For acute dystonias, Diphenhydramine, 50 mg., or Benztripine, 2 mg. is given parenterally. A standing dose of antiparkinsonian is then prescribed to avert a recurrence.

d. For drug-induced extrapyramidal symptoms

Ref: Manual of Psychiatric Emergencies. Steven E. Hyman (Ed.), Little Brown and Co., Boston/Toronto, 1985.

EXERCISE #6

ANTIPSYCHOTIC MEDICATIONS

& THEIR SIDE EFFECTS

OBJECTIVE:

To identify specific interventions direct caregivers can use to assist residents in coping with the side effects of antipsychotic medications.

METHOD:

A copy of the attached worksheet is given to participants. The instructor explains that the list on the left hand side represents some of the more common side effects experienced by persons taking antipsychotic medications. The task is for the caregivers to develop a list of appropriate interventions for each of the side effects listed.

The instructor may refer to the accompanying list of suggested interventions if desired.

TIME: 20-30 minutes

NOTE TO INSTRUCTOR:

This exercise should be used only after a general discussion of psychotropic medications and their side effects.

EXERCISE #6 - ANTIPSYCHOTIC MEDICATIONS & THEIR SIDE EFFECTS

WORKSHEET

SIDE EFFECTS	INTERVENTIONS
SEDATION	
ORTHOSTATIC HYPOTENSION	
BLURRED VISION	
DRY MOUTH	
WEIGHT GAIN	
CONSTIPATION	
SENSITIVITY TO SUNLIGHT	
SUSCEPTIBILITY TO INFECTION	
LIVER DAMAGE	
EPS	
TARDIVE DYSKINESIA	
ACUTE MUSCLE SPASM	

EXERCISE #6 - ANTIPSYCHOTIC MEDICATIONS & THEIR SIDE EFFECTS

INSTRUCTOR'S GUIDE TO INTERVENTIONS

SIDE EFFECT	INTERVENTION
SEDATION	ASSIST WITH DAILY ACTIVITIES AS NECESSARY TO PREVENT INJURY FROM FALLS, BURNS, ETC. SEDATION SHOULD SUBSIDE AS BODY ADJUSTS TO MEDICATION. CONTINUED SEDATION WITH NO RELIEF SHOULD BE REPORTED TO MEDICATION NURSE.
ORTHOSTATIC	ASSIST WITH MOBILITY IF NECESSARY. HYPOTENSION TEACH RESIDENT TO RISE SLOWLY FROM SITTING TO STANDING POSITION. ENCOURAGE TO SIT ON THE SIDE OF THE BED FOR A FULL MINUTE BEFORE GETTING UP.
BLURRED VISION	REMOVE CLUTTER AND OTHER HAZARDS FROM THE ENVIRONMENT. THIS SHOULD CLEAR UP IN TIME, SO NO IMMEDIATE CHANGES IN PRESCRIPTION GLASSES SHOULD BE MADE.
DRY MOUTH	OFFER SUGAR-FREE GUM, HARD CANDIES, LIP BALM FOR DRY LIPS, AND ICE CHIPS.
	WEIGHT GAIN ENCOURAGE LOW CALORIE SNACK FOODS, FRUITS,ETC. ENCOURAGE EXERCISE.
CONSTIPATION	INCREASE FIBER IN DIET. EXERCISE. MILD LAXATIVE, IF NEEDED.
SENSITIVITY SUNLIGHT	PROTECT WITH SUNSCREEN, SUN-GLASSES, TO CLOTHES, WIDE BRIMMED HAT. SIT IN SHADE WHERE POSSIBLE.
SUSCEPTIBILITY TO INFECTION	REPORT COMPLAINTS OF SORE THROAT, ANY OTHER INFECTIONS. REPORT FEELINGS OF MALAISE.
LIVER DAMAGE	OBSERVE SKIN AND SCLERA (WHITE OF THE EYE) COLOR. REPORT IF THERE IS A YELLOW COLOR.
EPS (Frightening and often uncomfortable neurological side effects)	ASSESS AND REPORT CHANGES IN THE FOLLOWING AREAS: * HOW RESIDENT WALKS AND STANDS * RIGIDITY OF LIMBS * FACIAL EXPRESSION * TREMORS IN HANDS * RESTLESSNESS * WEAKNESS AND FATIGUE

(MAY ALSO NEED HELP IN EATING, GROOMING, HYGIENE, AND MOBILITY)

TARDIVE DYSKINESIA (a type of EPS that is potentially irreversible)	REPORT ANY UNUSUAL MOVEMENT OF TONGUE, FACE AND JAWS. PEOPLE MAY NEED ASSISTANCE WITH EATING, TAKING MEDICATIONS, AND ORAL HYGIENE.
ACUTE MUSCLE SPASMS	RECOGNIZE THE FOLLOWING SIGNS AND SYMPTOMS AND REPORT: * FIXED STARE * NYSTAGMUS * OPEN, GAPING MOUTH * PROTRUDING TONGUE * HEAD TILTED BACK * FACIAL EXPRESSION OF PAIN * TWISTING OF NECK * EYES ROLLED BACK IN HEAD CALL FOR HELP MAKE RESIDENT AS COMFORTABLE AS POSSIBLE PROVIDE COMFORT AND ASSURANCE

HANDOUT #8

PSYCHOTROPIC MEDICATIONS

SIDE EFFECTS	INTERVENTIONS
Drowsiness Dizziness Hypotension Blurred Vision	Ensure the safety of the resident while his body adjusts to the medication. Encourage rising slowly and using furniture to hold on to if necessary. Assist with mobility when needed. Keep floors clear of clutter. When checking blood pressure, take it with the resident both lying down and then standing. A fall of 30mm. Hg or greater is significant. Remember that orthostatic hypotension can result in falls that can lead to fractures or other injuries.
Dry Mouth	For dry mouth,try sugar-less candy or gum. Lip balm may also ease dry lips.
Nasal stuffiness	Vaporizer may be helpful.
Constipation	Encourage bran, fluids, fresh fruit and vegetables. A mild laxative may be helpful.

ANY OF THE SIDE EFFECTS LISTED ABOVE MAY SIGNAL A NEED FOR A CHANGE IN MEDICATION OR A CHANGE IN DOSAGE. RECORD AND REPORT YOUR OBSERVATIONS.

SECTION C

BEHAVIORAL

MANAGEMENT

There are few experiences so demoralizing to a caregiver (particularly a new worker) than being frightened or struck by a resident who is out of control. In this unit some of the basic principles of behavioral management are discussed, including the importance of knowing the resident and how the behavioral response of one individual affects that of another. Violent behavior and the post incident conference are also briefly addressed in this section.

CONTENT:

Background Information - Behavioral Management.......pp. 47-53

Exercise #1 - Personal Encounters...................pg. 54

Exercise #2 - Role Play.............................pg. 55

Handout #1 - Post Incident Conference...............pg. 56

Handout #2 - Responses to Maladaptive Behavior......pg. 57-60

LECTURE BEHAVIOR

Of the hundreds of training programs this team has presented, the most frequent requests concern the management of difficult behavior. Working with clients who make unreasonable demands, who become angry, who deny reality, are verbally abusive, or act helpless, can be both physically and emotionally draining. While there are no easy or given solutions to these behaviors, there are basic strategies that have proven extremely helpful to those who work with difficult clients.

I'm sure everyone here can remember "taking" or "breaking" something apart for the sole purpose of looking inside to see how it worked. Today, we want to do something similar with behavior, take it apart, look inside and learn something about the way it works.

At its root, most negative behavior can be traced to a personal loss or perceived threat. Think for a moment of the residents you care for. In particular, think of the losses they have sustained that has brought them to this point in their lives.

NOTE: To encourage group participation, the instructor might use the following exercise. (The sample chart on page 50 will serve as a guide.)

After making the three columns and heading them as shown, (LOSSES) (FEELINGS) (BEHAVIOR) the instructor should ask the following three questions in order, listing the responses in the appropriate columns.

1. Can you name some of the losses your residents here have experienced?
2. Can you describe the feelings that these losses might generate?
3. As caregivers, what kinds of behavior do you see as the result of these feelings?

We can easily see that **LOSSES, FEELINGS** & **BEHAVIOR** are intimately related to each other. Perhaps their strongest link is their connection to our self worth. A short comment about each will demonstrate this connection.

1. **LOSS** The bigger the loss, or greater the accumulation of losses, the more devastating the blow to the self worth.
2. **FEELINGS** Result from the emotional pain of a wounded or threatened self worth.
3. **BEHAVIOR** Reflects attempts to protect ourselves from the pain that these feelings inflict.

There are three very important pieces of information that we should carry away from this exercise.

FIRST "All behavior has meaning." I'll never forget a story related by a caregiver who worked with a woman who constantly screamed. At times she felt that she couldn't tolerate another moment. Then a member of the patient's family told the caregiver of the terrible life of abuse this woman has suffered. After that, the worker stated, "The screaming didn't seem so loud anymore." As we view the behaviors we encounter as expressions of anguish, frustration, grief or a cry for help, our own attitudes toward their residents will be profoundly effected. Thus, it becomes important for staff to "know their residents." When assigned a new resident, staff should endeavor to learn the following information:

1. As much of the personal history as possible, including where the resident was born, the kind of work he/she did, marriage, children, etc.

2. Major health concerns, including current treatment plan.

3. The experience of other staff with the resident.

This information enables staff to interact with residents in a more meaningful way. It will also (as with the screaming patient) help staff to understand some of the feelings which lie behind the behavior. Simply to know, for instance, that a certain resident was a lawyer and had engaged a degree of personal power, will help us better understand how institutional living might threaten his self-esteem. One of the most important aspects of behavioral management is the establishment of personal relationships between resident and staff. This becomes a matter of great concern as we consider the climate of today's long term care workplace, where the annual turnover rate can be as high as 80%. It is easy to appreciate how difficult it must be for the resident who must continually adjust to new faces and new personalities, particularly at a point in their lives when structure, routine, and stable relationships are so important. It is also important, when orientating new workers, that enough time be allowed for staff and resident to develop some comfort level with one another.

SECOND If we are to effectively deal with the behavior, we must address the feelings that lie behind the behavior. In other words, if we want to change the withdrawn or agitated behavior, then we must somehow touch the loneliness, the feelings of uselessness or anger that lie behind the behavior.

THIRD

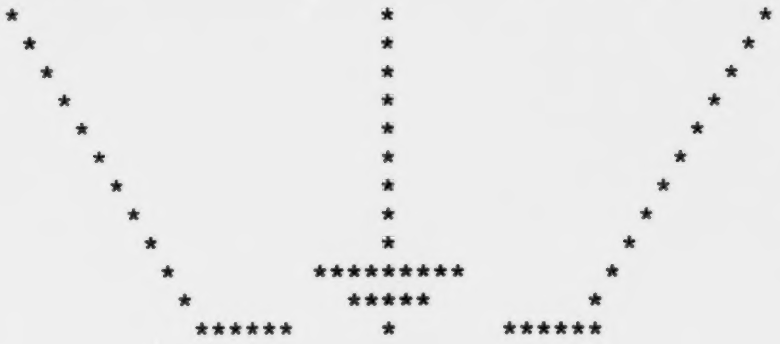
Feelings that are kept inside can be very destructive. Open-ended type questions can be a valuable tool when staff wish to encourage residents to express their feelings.

If someone asks a resident, "You're unhappy about being here, aren't you?", the probable response would be either yes or no. On the other hand, if one used an open-ended statement such as, "You seem to be unhappy. Tell me what you are feeling", the statement cannot be answered with a simple "yes" or "no". He will have to elaborate on his response. This provides the staff an opportunity to further discuss the resident's feelings. "Tell me the reason your so unhappy", "What happened, that you came here to live?", "What did you used to do when you faced hard times?", "Can you tell me what you are feeling?", are all examples of open ended questions. If residents do discuss painful feelings, they need encouragement and support. Staff should look at the resident in an interested and concerned manner. Encourage the resident by phrases such as, "Yes, I see", "Go on", "I can understand that". Such statements will let the resident know that you are interested and listening to what is being said.

BEHAVIOR LECTURE

SAMPLE CHART

LOSSES	FEELINGS	BEHAVIOR
HOME	ANGER	DEMANDING
INDEPENDENCE	FRUSTRATION	VERBAL-ABUSE
SPOUSE	DEPRESSION	AGGRESSION
FRIENDS	USELESSNESS	WITHDRAWN
HEALTH	LONELINESS	
OCCUPATION		
ABILITIES		
The bigger or greater the accumulation, the more devastating to the self worth	Results from the pain of wounded or threatened self worth	Attempts to protect ourselves from pain that feelings inflict.



SELF WORTH

1. All behavior has meaning.
2. To effectively deal with the behavior - must address feelings behind behavior.
3. Feelings kept inside can be very destructive.

ONE'S BEHAVIORAL RESPONSE CAN INFLUENCE THE BEHAVIOR OF ANOTHER

It's an interesting fact that, in communication, the actual words we speak account for only 10% of the message being sent, while the tone of voice, facial expression, and body language account for the remaining 90%. As an example, consider the phrase, "Come over here." With a playful lilt in the voice, slightly raised eyebrows and a little toss of the head, "Come over here," could be interpreted as a rather suggestive invitation. But if the voice were lowered, the head tilted, and the arms outstretched, the same phrase could be a sympathetic invitation to console. If, on the other hand, the eyebrows were pulled together and the voice strained, "Come over here," could be downright intimidating.

It is important to note that each different expression of this phrase will generate a different response in the receiver of the message. These responses might include shock, embarrassment, relief, trust, distrust or fear. How often our strong inner feelings betray the words we speak!

At this point the instructor might write the following words on the black board/flip chart:

1. VOICE
2. FACIAL EXPRESSION
3. BODY LANGUAGE
4. DISTANCE

Each of us, through our life experiences, has developed different methods of coping with difficulty, fairly standard ways that we respond when confronted with different situations. For example, when someone raises his/her voice at us, what do we do as a rule? We may begin to raise our voice right back. When confronted with angry or threatening behavior, our blood pressure rises and we grow just a little taller, don't we? What about distance? When someone steps too close to us (invades our space), what do we do to be comfortable? We need to step away.

Because one's behavioral responses can influence in such a powerful way another's behavior, it becomes extremely important that caregivers "know themselves," their physical, emotional, and physiological limits. Ask yourself, "Is this the type of client you have shown decreased tolerance to, and increased vulnerability to in the past?" Remember, each of us has tremendous potential to de-escalate a crisis. If we control ourselves, most often, we can save others the embarrassment of losing control.

Patients with mental illness often use staff as role models and pattern their behavior and even their communication style after the person with whom they are working. Therefore, it is important to give residents a good role model.

NOTE TO THE INSTRUCTOR:

The role play as outlined in exercise #2 can be appropriately used here to illustrate the caregiver's "de-escalating" potential.

A crisis is always most effectively handled at the developing stage before it escalates into emergency proportions. This is particularly critical for the violent client who is at high risk for loosing control. When working with clients who are inclined to lose control, caregivers should keep the following information in mind.

The hostile or violent client has real difficulty maintaining internal control The possibility of losing control is extremely frightening to the client. Statements such as, "I'm afraid that I'm going to do something bad," or "I'm afraid that I might hurt someone," are often cries for help. The staff need to reassure the client that they are there to help and will not allow him to lose control or will be there to help control those urges if needed.

Strong ultimatums or threats such as "If you don't stop that right now, this will happen," often places the client in an awkward situation. While he may not want to lose control, he may want to lose face in front of others even less. Give the client every opportunity to save face. If the client displays angry behavior, address those feelings. "You seem to be feeling angry (address the client by name). Can you tell me more about that?" By expressing himself, the client is able to vent some of the emotions he is feeling.

Clients who are paranoid are among the easiest to provoke to a more agitated state. This type of client is likely to "read" every move you make. A hand moved to cover the mouth, a smile, or a hasty remark, can affirm to the client that you are making fun of him or that you don't like him. Great sensitivity to our nonverbal language is needed when working with paranoid clients.

Most facilities require documentation following each disruptive incident. Recorded information generally includes the following:

WHO: Who was involved in the incident? Who was contacted?

WHAT: What happened before and after the incident? What type of restraint was used?

WHEN: When did the incident start? When did the incident end?

WHY: Why did the incident start?

These reports are important as they provide a basis upon which comparisons between past and future experiences which involve the client can be made. Many facilities are realizing the value of post-incident conferences as well. These are meetings which are held as soon after the incident as possible, and attended by all parties involved, including the client if at all possible.

The post-incident conference provides an opportunity for staff to review the incident and to analyze how well they worked together as a team. Often a disruptive episode can leave both client and staff with feelings of anger and frustration. These feelings, if carried inside, become barriers to the development of healthy client-staff relationships. In the post-incident conference, client and staff can discuss together their feelings about what happened. This not only allows the anger and frustration to be vented, but helps the client to understand why he lost control and explore with staff other ways of handling his feelings. This can only result in stronger relationships between staff and clients and greater skill and effectiveness in resolving behavioral difficulties in the future.

EXERCISE #1

PERSONAL ENCOUNTERS

OBJECTIVE:

To encourage group participation and to find common denominators in residents' personal experiences with aggressive behaviors.

METHOD:

The instructor asks the following question, "How many can remember the most difficult or frightening experience you have ever had involving a resident? Would some of you be willing to share that experience with the rest of the group?"

Note: The discussion should bring out information relevant to areas which will be discussed in this session, namely: 1) the importance of knowing the resident; and 2) how our own responses affect the behavior of others.

DISCUSSION:

The following questions will help the instructor to explore the circumstances of each experience:

1. Were you new on the job when this occurred?
2. Do you remember how you were feeling during the experience?
3. What was your immediate response to the resident's behavior?
4. How did the problem finally get resolved?
5. Were you eventually able to work effectively with this resident? What do you think made the difference?

TIME: 10 - 15 Minutes

EXERCISE #2

ROLE PLAY

OBJECTIVE:

To demonstrate to participants how one person's behavior, positive or negative, can directly influence the behavior of another.

METHOD:

Four participants are needed for this role play:

1. Resident: Judy
2. Resident: Frances
3. New worker: Norman
4. Experienced worker: Linda

Prior to this exercise the instructor should choose the players and explain their roles individually so that the exercise can proceed smoothly. Explain to participants that they are to be observers and note the proper or improper use of, tone of voice, facial expressions, body language, and distance.

> Judy is eating at the dining room table. Frances, looking confused, walks up to table and begins taking food from Judy's plate. This causes an argument and a commotion in the dining area. Norman hears the noise and comes running in (seems unsure of himself). Seeing what is happening he rushes up to Frances (very close), placing his hands on his hips he shouts, Frances! What are you doing? Get away from there!" Frances seems startled and, as her behavior begins to escalate, Norman holds her arm sternly and attempts to take her out of the room. Frances then strikes Norman in the face. At this point Linda walks in. Keeping proper distance she asks Frances if she can help her. After talking softly to Frances for a while, Linda invites her to come to another table where she will get her some food. Frances (calmed down) follows.

DISCUSSION:

1. Is Frances's state of mind vindictive or confused? Did her behavior merit Norman's approach?
2. Was Norman's use of voice tone, facial expression, body language, and distance appropriate?
3. How did Norman's behavior affect Frances?
4. How appropriate was Linda's approach?
5. Ask the player who played Frances how the approaches of both Norman and Linda made him/her feel
6. How should this incident have been initially handled?

TIME: 15 - 20 Minutes

HANDOUT #1

POST-INCIDENT
CONFERENCE

Discuss both individual and group strengths and weaknesses

Self

a. How could incident have been prevented?

b. Examine own reactions

c. Judgement, Intent, Use of force: Were they all met?

Group

a. Did the team work well together?

b. Communication

c. Mobilization

d. Is one client or staff always the target?

Client

a. Different or same as other incidents? In what way?

b. Discuss feelings of losing control

c. Explanation of intervention

d. Discuss responsibilities of both client and staff in maintaining control

e. Review procedures for future incidents

HANDOUT #2

RESPONSES TO MALADAPTIVE BEHAVIORS

I. RESPONSES OF STAFF TO PATIENTS' MALADAPTIVE BEHAVIOR

A. Responses to Agitated, Hyperactive, Destructive and Combative Patients

1. Intervenes immediately when patient needs controls or limits
2. Approaches patient in non-threatening manner; allows him physical space
3. Refrains from reacting solely on emotional basis
4. Is firm but understanding; does not show fear
5. Consistently enforces limits
6. Refrains from arguing with or further provoking patient
7. Attempts to discover cause for disturbance
8. Helps patient verbalize feelings and discuss problems
9. Removes patient to nonstimulating, safe environment
10. Reassures, supports, calms, and soothes
11. Provides appropriate diversion
12. Provide patient with appropriate physical activity
13. Through actions, assures patient that his behavior has not alienated staff members
14. Encourages patient to understand, control, and accept responsibility for his/her own behavior
15. Reinforces positive behavior

B. Responds to Hostile, Verbally Abusive Patients

1. Remains calm in face of abuse
2. Refrains from arguing with or further provoking patient
3. Helps patient understand and express his feelings and find methods of coping with them
4. Reassures, supports and calms
5. Discourages hostile behavior without rejecting patient

C. Responds to Suicidal or Self-Abusive Patient

1. Closely observes patient for signs of suicidal intent; recognizes seriousness of behavior
2. Prevents patient from harming himself
3. Is warm and reassuring; offers support and external control
4. Points out positive aspects of patient's life
5. Recognizes and does not reinforce inappropriate bids for attention

D. Responds to Patients who Elope or Want to Leave Treatment

1. Is alert for signs of intent to leave and takes preventive action
2. Remains calm; avoids further agitating patient
3. Uses proper precautions around doors to locked units
4. Uses diversionary methods and incentives
5. Sets firm limits within patient's legal rights
6. Encourages patient to continue therapy, as appropriate
7. Shows concern for patient's welfare
8. Uses good judgement in pursuing and returning patient
9. Recognizes and does not reinforce inappropriate bids for attention

E. Responds to Uncooperative Patients

1. Is aware of patient's fears and tries to alleviate them
2. Confronts patient and explores with him his feelings and reasons for uncooperativeness
3. Calmly gives patient explanations
4. Is patient and reassuring, avoids threats or physical force
5. Allows patient to choose between alternatives
6. Firmly insists on cooperation; does not give in
7. Through actions, assures patient that his behavior has not alienated staff members
8. Accepts isolated instances of uncooperativeness or regression without overreacting

F. Responds to Patients who Violate Rules

1. Maintains composure; correctly assesses severity of offense and appropriateness of consequences
2. Confronts patient about violations and sets firm limits
3. Makes sure rules are clearly communicated
4. Uses tact in pointing out violations

G. Responds to Patients Suffering from Restlessness, Insomnia

1. Calms and reassures patients by talking and listening to him
2. Prevents patient from disturbing others by moving him if appropriate
3. Arranges milieu conducive to sleep and rest
4. Offers companionship, food, or quiet activities to restless patient

H. Responds to Withdrawn or Depressed Patients, Patients with Low Self Esteem

1. Approaches patient in nonaggressive manner
2. Is firm in getting patient out of bed and/or involved in activities
3. Shows personal interest in patient and encourages trust
4. Helps patient to discuss and understand problems
5. Helps depressed patient release underlying anger
6. Encourages patient to see positive aspects of self
7. Provides activities that encourage interaction and self-esteem

I. Responds to Patients Fighting, Arguing with or Irritating Each Other

1. Remains objective in quarrels between patients
2. Points out behavior that offends others
3. Helps patient discuss feelings about each other
4. Helps patients resolve quarrels without violence
5. Separates and/or distracts quarreling patients if indicated

J. Responds to Pesky, Nagging, Demanding Patients

1. Controls own irritation
2. Teaches and encourages appropriate methods to gain attention
3. Confronts patients with behavior if appropriate and sets limits
4. Listens to patient and tries to give needed reassurance
5. Provides schedule for frequent, brief contacts

K. Responds to Tearful, Distressed Patients

1. Shows concern and understanding
2. Helps patient talk about and accept feelings of distress
3. Calms, supports and reassures patient

L. Responds to Patients who are Fearful, Anxious, or Worried

1. Helps patient identify his fears, anxieties and worries
2. Offers reassurance and encourages trust
3. Is friendly but not aggressive
4. Takes specific action to allay patient's expressed fears

M. Responds to Patients Demonstrating Inappropriate Manipulative Behavior

1. Ignores obvious attempts to irritate
2. Consistently avoids giving desired response
3. Sets firm limits for patient who is "testing"
4. Confronts patient with behavior, if appropriate

N. Responds to Compulsive Behavior and Ritualism

1. Helps patient control compulsive behavior, if indicated
2. Gives encouragement and support to non-ritualistic behaviors

O. Responds to Patients Exhibiting Bizarre Behavior

1. Responds as soon as patient needs controls
2. Helps patient understand and control his behavior if indicated
3. Avoids reinforcing bizarre behavior
4. Reorients patient to reality gently, without demanding

P. Responds to Patients Demonstrating Inappropriate Sexual Behavior

1. Maintains non-condemnatory, accepting attitude
2. Sets firm limits

Q. Responds to Disoriented, Confused, or Incoherent Patients

1. Gives patient necessary information and assistance as often as necessary
2. Is patient; does not hurry patient
3. Is kind and firm in helping patient behave appropriately
4. Provides reality-oriented conversation topics or objects in the environment

R. Responds to Patients who are Experiencing Hallucinations

1. Removes hallucinating patient from stimulating environment if indicated
2. Shows kindness, concern
3. Focuses patient on reality
4. Calms patient by talking and listening
5. Reassures and supports patient by talking and listening

S. Responds to Paranoid or Delusional Patients

1. Avoids provoking, agitating, or arguing
2. Focus patient on reality and avoids reinforcing delusions
3. Develops trusting relationship to lessen fear

T. Responds to Patients who Lie or Steal

1. Confronts patient with behavior and teaches alternative behavior
2. Uses tact in confronting patient

U. Responds to Patients who Exhibit Poor Hygiene or Self-Care

1. Uses patience and repetition to form health routines
2. Uses reward appropriately
3. Is kind but firm in encouraging patient to care for himself

Text: Critical Behaviors in Psychiatric-Mental Health Nursing

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Volume II Behavior of Attendants

By: Jacobs, Angeline
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UNIT #4

UNDERSTANDING DYSFUNCTIONAL BEHAVIOR

OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION A: To assist participants in recognizing the more common defense mechanisms used by residents experiencing episodes of anxiety	Exercise #1 Defense Mechanism	Group Discussion with Handout	15-20 minute
Section B To identify signs and symptoms of psychotic behavior	Exercise #1 Visualization Reality Orientation	Individual/ Experiential Activity	10-15 minute
	Exercise #2 Auditory Hallucinations	Group Activity and Discussion	15-20 minute
	Exercise #3 Responding to Hallucinations and Delusions	Individual or Group Activity and Discussion	15-20 minute
To identify signs and symptoms of late-life paranoia	Exercise #4 Visualization Paranoia	Individual or Group Activity and Discussion	15-20 minute
	Exercise #5 Case Study	Group Activity and Discussion	15-20 minute
To review interpersonal interventions for working with dysfunctional behaviors	Discussion and Handout #2	Mini Lecture followed by Group Discussion	20-25 minute
To review medications used as therapy for dysfunctional behaviors including side effects	Discussion and Handout #3 and #4	Mini Lecture and Group Discussion	30 minute
	Exercise #6	Group Activity and Discussion	15-20 minute

UNIT #4

UNDERSTANDING

DYSFUNCTIONAL BEHAVIOR

OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION C			
To demonstrate the importance of developing a therapeutic relationship with the resident	Exercise #1 Sharing of Personal Experiences	Self-Assessment and Group Discussion	10-15 minute
To demonstrate how participants' behaviors influence residents' behaviors and participants' potential for de-escalating crisis	Exercise #2 Behavioral Influences	Role Play and Group Discussion	15-20 minute
	Group Discussion - The Violent Client	Handout #3 and Group Discussion	15-20 minute
	Group Discussion - Post Incident Conference	Handout #3 and Group Discussion	15-20 minute

DEMENTIA

UNIT #5

UNIT #5

DEMENTIA

Unit #5 discusses Dementia as it relates to the elderly in long-term care settings. The unit begins with a very basic discussion of how the brain controls behavior, and how behaviors change as a direct result of chemical, disease, or traumatic injury to the brain. The discussion includes an overview of reversible and irreversible types of dementia. The primary focus of this unit is on Alzheimer's Disease and the unique care needed by people who suffer from this disease. Section A provides an overview of Dementia as a disease process. Section B describes the most common caregiving problems faced by those who provide direct care. Emphasis is placed on the reasons for these problems, and possible caregiving interventions. Learning exercises offer staff opportunities to use their own experience and creativity in planning individualized care.

OBJECTIVES:

Section A To review the differences between causes of reversible and irreversible dementias.

To discuss the relationship between brain function and irreversible dementias.

To review the stages of cognitive decline in Alzheimer's Disease and their relationships to care planning.

Section B To discuss communication needs of residents with dementia and interventions for enhancing communication.

To identify the most common troubling behaviors associated with dementia and to consider helping interventions.

CONTENT:

Section A - Dementia................................pp. 1-22

Section B - Behavioral Management for Dementia Victims ......pp. 23-43

References...pp. 44-45

SECTION A

DEMENTIA

CONTENT:

Background Information - Dementia ....pp. 2-4

Handout #1 - Treatable Causes of Dementia ....pp. 5-7

Background Information - Cognitive Decline in Dementia..pg. 8

Handout #2 - Stages of Cognitive Decline ....pp. 9-11

Exercise #1 - Living with Grace ....pg. 12

Exercise #2 - Behavior Changes Related to Dementia......pp. 13-15

Exercise #3 - Making a Telephone Call...................pp. 16-17

Exercise #4 - Activities for Residents with Alzheimer's Disease ....pp. 18-21

Handout #3 - Do You Remember Love ....pg. 22

DEMENTIA

Background Information:

If you work in a nursing home, statistics indicate that at least 50% of the residents for whom you care have some degree of dementia. For the purposes of this unit, the word dementia will be defined as a medical condition that is characterized by a variety of symptoms of intellectual loss and deterioration severe enough to interfere with the activities of daily life and which occur when the person is awake and alert.

This is in contrast to the condition of delirium which involves behaviors similar to dementia, but which occur in an altered state of consciousness.

Typical symptoms and behaviors of dementia may include the following

Symptoms	**Behaviors**
Disorientation from time, place or person	Resident may not know where they are, what day, month or year it is. They may not recognize staff or family members. May appear confused, especially at night.
Memory impairments	The passage of time has no meaning for the resident. The concept of yesterday and tomorrow is lost. Long-term memory is retained longer than short-term memory. At first, forgetfulness may be denied. There may be a noticeable hesitation and search for words when the resident is trying to converse.
Impaired Judgement	Resident may pick up hot items with no protection, try to eat inedible things and wander into dangerous situations. May take others' belongings or give theirs away. Dress may be inappropriate. May hide items.
Decline in ability to learn	Unable to comprehend new ideas, or to learn new tasks, names, or places. May get lost in new surroundings, unable to find even their own room in a new environment. Attention span for any activity grows shorter.

Symptoms	Behaviors
Inappropriate emotional response to events	Residents may laugh at something that is not funny or cry when there appears to be nothing to cry about. Moods and emotions change quickly with no apparent reason. They may not be able to explain why they are laughing or crying
Lowering of ethical or behavioral standards	May be unable to control feelings and needs. Use foul language, expose self, or masturbate in inappropriate environments. Social manners are not remembered and, therefore, not practiced.

It is important to remember that people with dementia react in different ways to their environment and those within. Their personalities may change rapidly from compliant and cooperative to angry and hostile for what seems to be no apparent reason. They may become depressed and irritable. Many times the residents are responding to feelings that are often not well understood.

The severity of dementia will directly affect the kinds of behavior that you observe. At first the changes may be very subtle and difficult to assess. Never the less, accurate assessments and diagnoses are critically important. Again, remember that dementia is not the natural result of growing older. It has a specific, and usually identifiable, cause. Even if the dementia is not treatable, a proper evaluation is an important first step in developing a realistic and therapeutic plan of care.

IRREVERSIBLE DEMENTIA

Irreversible (or primary) dementias are those which arise spontaneously with no known cause and for which no effective treatment is known. The two most common types of irreversible dementias are multi-infarct dementia and Alzheimer's Disease. Because of its prevalence among the elderly, this unit will emphasize Alzheimer's Disease.

The cause of Alzheimer's Disease (named after the German physician who described it in 1907) remains a mystery. Diagnosis is made by the process of elimination; all treatable causes of dementia, i.e., drug intoxication, depression, etc., are ruled out with a thorough medical, neurological and psycho-social evaluation. Following the evaluation, the diagnosis of Alzheimer's is made on the basis of symptoms and the ways in which the symptoms progress over time. An absolute diagnosis can only be made after death with an autopsy on the brain, as the tissues affected by this disease exhibit several distinguishing characteristics.

Alzheimer's Disease is a dementia that usually progresses slowly. An insidious disease, it may go unnoticed during the early stages. The physical changes that occur over time affect primarily the cerebral cortex of the brain (the outer layer of the brain). Changes in nerve cells prevent the transmission of messages to other parts of the brain. Plaque is formed on the nerves, and neurofibrillary tangles develop. The other changes that are seen in an autopsy include enlarged spaces in and shrinking of sections of the brain that control thinking, memory and judgement. Currently, there is no known treatment for Alzheimer's Disease nor are its causes known.

As the disease progresses, dramatic changes in behavior can be observed. The centers of the brain that control behavior no longer function normally. Messages to and from the other centers of the brain and other areas of the body become lost. Messages no longer make sense to persons with dementia, and they lose the ability to interpret what is happening in their environment. Behavior deterioration can be very subtle at first. As the disease progresses, and more behaviors are affected, the changes are much more pronounced.

Persons with Alzheimer's Disease and other progressive disorders are unable to learn new information and behaviors. They have lost the ability to remember and retain thoughts and ideas. Other areas of the brain cannot be retrained to assume lost functions. The emphasis of treatment, as the disease progresses, is placed on those functions that have been retained.

MULTIINFARCT DEMENTIA

Multi-infarct dementia occurs when blood circulation to the brain is impaired and nerve cells no longer receive the nourishment that is required to keep them functioning. Multi-infarct dementia may be caused by blood clots in the arteries leading to the brain (often occurring in the arteries of the neck and heart). Multi-infarct dementia may also result from untreated hypertension.

The onset of a multi-infarct dementia may be sudden or gradual. The course of the disorder can be also gradual and intermittent. Damage to the brain can be in one area or throughout. Softening of brain tissue and bleeding often occurs with this disease. In patients with hypertension, atrophy of the brain and nerve cell destruction may be seen. Changes in the blood vessels such as atherosclerosis are also seen.

Resulting damage to the brain from this disease may also bring about significant observable changes in behavior, depending on the area of the brain affected. It is possible for affected persons to re-learn skills as they may not have lost the ability to remember directions nor the ability to read and to comprehend.

TREATABLE CAUSES OF DEMENTIA

There are over one hundred different possible causes of dementia. In at least 15% of all diagnosed cases of dementia, the cause is either reversible or treatable. Because of the myth that dementia occurs as a natural function of aging, symptoms may be ignored or attributed solely to one's age. This is most unfortunate because to condemn an individual to an erroneous diagnosis of progressive and degenerative disease is to eradicate all hope for further assessment of the individual's status and, thus, that person's opportunity to get better.

HANDOUT #1

TREATABLE (REVERSIBLE) CAUSES OF DEMENTIA

D..........Drug reaction or interactions or poisoning from overdose

E..........Emotional disorders

M..........Metabolic and/or endocrine disorders

E..........Eyes and ears (sensory loss)

N..........Nutrition loss

T..........Tumors

I..........Infection

A..........Arteriosclerosis

HANDOUT #1 - TREATABLE CAUSES OF DEMENTIA

DISCUSSION MATERIAL

Drug interactions and reactions (including overdose) may result in demented behavior. Some of the known side effects of many medications prescribed for the older person have included decreased mental alertness and/or confusion. Sometimes, common medications like Digitalis, anti-hypertensives, and diuretics can become toxic, even in therapeutic doses. As the body reacts to the toxicity, mental confusion and disorientation may result. You may recall from earlier discussions, that the body changes as we grow older. These changes result in alterations in the way we store, metabolize, and excrete medication. These changes may result in a build-up of accumulated medication in the system which exceeds the therapeutic range. Previously therapeutic doses may need to be reevaluated as the person ages.

Emotional disorders, especially depression, may cause someone to respond with dementia-like symptoms. Because depression is the most prevalent mental health disorder among the elderly (estimates are that close to 75% of all residents in long-term care facilities suffer from at least one episode of depression), you are likely to see these symptoms in the residents for whom you care. The emotional isolation and withdrawal that are characteristic of depression can also be a cause of such dementia-like symptoms as impaired thinking, confusion and disorientation. Remember that depression is treatable. Report your observations so that an appropriate referral can be made if necessary.

There are many metabolic and endocrine disorders and/or imbalances that can occur in the body. Sometimes even minor changes in the delicate balance can affect cognitive behavior. Some of the more common problems are liver and kidney disorders, COPD, electrolyte imbalance, thyroid disease, adrenal disorders or hypoglycemia.

There are certain changes that occur both in vision and hearing as one ages. In addition, we become more susceptible to certain diseases of the eye and ear. Any process that decreases the amount and quality of sensory input increases the chance that disorientation and confusion can occur.

Nutritional loss, either from malnutrition or losses that occur as a result of being confined to bed, can cause symptoms of dementia. Depressed elderly persons and those living in social isolation are less likely to maintain good eating habits.

A tumor in the brain may eventually cause behavior changes, including those that resemble dementia.

Infection may be a cause of demented behavior. Infection in the elderly is often undetected as it does not always have the usual signs and symptoms, i.e., fever and pain. Never the less, infections, especially respiratory and kidney infections, are common and may eventually cause mental confusion and disorientation if left untreated.

Alcohol use, current or past, causes memory defects (Wernicke - Korsakoff). This may exist with other dementias.

Finally, arteriosclerotic disease can cause mental confusion, forgetfulness, and disorientation. Any process that disrupts the flow of blood, and therefore oxygen, to the brain, will cause cognitive changes. The most common affliction may be congestive heart failure, but may also include hypertension.

As a direct caregiver, you will likely to be the first to observe changes in the behavior of the residents for whom you care. If these changes resemble any of the symptoms that have been described, it is most important that you do not disregard them or attribute them to old age. The behaviors that you observe should be documented and reported accurately so that appropriate referrals can be made.

COGNITIVE DECLINE
IN ALZHEIMERS DISEASE

Background Information:

The progressive nature of decline in Alzheimer's Disease is described by noted authority, Barry Reisberg, M.D., as a reverse cognitive development. He describes it in seven stages outlined on the following pages. Conceptually, it follows a pattern of normal development in reverse.

Our cognitive abilities, our memory, intellect, judgement, and reasoning capacity, develop in a progressive fashion from birth to adulthood. Under normal circumstances, our abilities become more sophisticated as we develop from infant to toddler to child to adult.

Reisberg describes the cognitive decline that occurs in a dementia of the Alzheimer's type as a reverse process of what occurs in normal growth and development. In other words, the disease begins in the brain of an adult with normal intellect. As it progresses, the person's intellectual abilities are lost in the reverse order in which they were gained. Abilities which diminish first are those of a child, then a toddler, then an infant. In the final stages of the disease, the adult will likely be confined to bed, unable to speak words, unable to communicate except at the most primitive level, unable to chew and incontinent of urine and feces, much the same clinical picture as a new born baby.

This concept of loss of cognitive abilities may be helpful to recall as decisions are made in planning care for the resident. Clearly, considerations about safety, diet, exercise, communication and activity must be made with the client's current abilities in mind. A person functioning at the level of a twelve year old will have a plan of care very different from the resident who functions at the level of a two-year-old.

HANDOUT #2

STAGES OF

COGNITIVE DECLINE

(From the work of Barry Reisberg, M.D.)

STAGE I - NORMAL

CHARACTERISTICS: Many older people experience little or no change in intellectual functioning.

FUNCTIONAL CAPACITY: No problem

IMPACT ON FAMILY: N/A

CARE NEEDS: N/A

STAGE II - NORMAL FORGETFULNESS

CHARACTERISTICS: Many people over age 65 complain of some decline in cognitive function, i.e., forgetting names, misplacing things, etc. May have some concerns that forgetfulness represents a serious problem.

FUNCTIONAL CAPACITY: No problems

IMPACT ON FAMILY: N/A

CARE NEEDS: N/A

STAGE III - EARLY CONFUSION

CHARACTERISTICS: Decline is severe enough to interfere at work or in social situations. May forget immediately what he is told, or people he is introduced to. May forget important meetings or co-workers. Many experience anxiety over the forgetfulness and attempt to hide impairment.

FUNCTIONAL CAPACITY: Difficulty in handling demanding employment and social interaction becomes evident to family.

IMPACT ON FAMILY: Family may begin to discuss person's retirement or cut back in activities.

CARE NEEDS: Caregivers should recognize that confusion may indicate problems other than dementia. If diagnosis is dementia, there may be no further decline for several years. Encourage manageable and enjoyable activities.

STAGE IV - LATE CONFUSION

CHARACTERISTICS: Decreased knowledge of current events. Some memory deficit in personal history. May still be oriented to time, person, and place if familiar. Becomes overwhelmed when faced with complex tasks.

FUNCTIONAL CAPACITY: Loses ability to handle routine activities like marketing, handling personal finances. Person may deny what is happening and emotionally withdraw.

IMPACT ON FAMILY: Families assist with finances and check on person frequently.

CARE NEEDS: Community support services needed. Have identification on patient's person.

STAGE V - EARLY DEMENTIA (Mod. Alzheimer's Disease)

CHARACTERISTICS: Unable to recall address/telephone number of many years. Memory lapses vary from moment to moment. Forgets names of family members seen less frequently.

FUNCTIONAL CAPACITY: Can no longer survive alone. Driving becomes a hazard.

IMPACT ON FAMILY: Family sees good days and bad days. Care is full time responsibility. Money for care becomes an issue. Wonder how far to push patient in activities.

CARE NEEDS: Caregivers need support.

STAGE VI - MIDDLE DEMENTIA (Mod - Severe Alzheimer's Disease)

CHARACTERISTICS: Forgets name of spouse. Forgets recent events almost immediately, but retains some memory of past events. Generally unaware of season, year, surroundings. Fearful of bathing, showers. May experience obsessive behaviors, shows a loss of will-power as he cannot hold a thought long enough to take action.

FUNCTIONAL CAPACITY: Inability to handle personal hygiene procedures in sequential fashion. Difficulty in dressing properly. Needs assistance to bathe. Unable to handle toileting. Urinary incontinence and fecal incontinence.

IMPACT ON FAMILY: Family often overwhelmed. Need much support. Patient may not recognize family. May discuss institutionalization.

CARE NEEDS: Tranquilizers may be used sparingly to control agitation.

STAGE VII - LATE DEMENTIA

CHARACTERISTICS: Brain appears to no longer tell body what to do. Verbal abilities are often lost. Ability to walk is lost. Incontinent of urine and feces, needs assistance with toileting and feeding.

FUNCTIONAL CAPACITY: Speaks only a few words. All vocabulary lost. Motor abilities lost. Stupor. Coma.

IMPACT ON FAMILY: Need for support continues. Support family in their efforts to maintain human contact with patient through loving touch and voice.

CARE NEEDS: Eating and mobility are ongoing care needs. Constant danger of choking, aspiration.

FROM: Reisberg, Barry, M.D., **"Stages of Cognitive Decline,"** **AJN**, February, 1984.

EXERCISE #1

LIVING

WITH GRACE

OBJECTIVE:

To familiarize participants to the impact of Alzheimer's Disease on the victim and family.

METHOD:

Film: "Living with Grace"

DISCUSSION:

This award winning film portrays five months in the life of a woman who suffers from Alzheimer's Disease. The film illustrates her loss of memory, emotional swings, catastrophic reactions, and confusion. It also vividly demonstrates the toll taken on the family caregiver, in this case, the husband. At the same time, it affirms the importance of a supportive caring environment for the person with this tragic disease. The film also supports, through illustration, many of the principles of care discussed in other parts of this unit.

The film, followed by discussion, offers a significant learning experience for health care providers. Because the characters in the film are real people, Glen and Grace Kirkland, the emotional impact on the audience is significant. Viewers will more clearly understand the needs of the client, as well as those of the caregiver.

TIME: Videotape = 28 minutes* - Discussion at instructor's discretion

* Living with Grace is available locally through the Alzheimer's Disease Project of Kennebec Valley, Dresden Avenue, Gardiner, Maine, for a nominal rental fee.

EXERCISE #2

BEHAVIOR CHANGES RELATED TO DEMENTIA

OBJECTIVE:

To assist participants in understanding the relationship between specific brain functions and behavior.

METHOD:

A brief review of the background information on multi-infarct dementia and Alzheimer's disease (pages 3 - 4) and the attached diagram of the brain is conducted as a prelude to this exercise. Handouts on brain function and behaviors are attached.

Participants are asked to consider a patient for whom they have cared who has had a diagnosis of either a multi-infarct dementia or Alzheimer's Disease. They are then asked to consider the behaviors listed on the attached handout, entitled "Behavioral Changes in Dementia," and try to identify those behaviors that they have observed in this individual. The instructor leads a discussion which attempts to relate the participants' observations with the particular disease process and how it affects the brain.

TIME: 15 - 20 minutes

EXERCISE #2 - BEHAVIOR CHANGES RELATED TO DEMENTIA

FUNCTION OF BRAIN

Judgement

Writing

Language (speech)

Emotional Response

Musical

Intellect

Motor Coordination

Skilled Movements

Reading

Memory

Touch

Vision

Hearing

Perception

Bodily Reaction

Creative Thought

Activation

Verbal (speech & interpretation)

EXERCISE #2 (CON'T)

BEHAVIORS SEEN IN THE DEMENTIAS

1. Losing Things
2. Writes notes as reminders
3. Forgets new information
4. Depression
5. Difficulty naming objects
6. Inappropriate dress
7. Forgets to complete a task
8. Incontinent
9. Becomes untidy
10. Excessive reactions to stress
11. Repetitive movements
12. Suspicious
13. Shaking, trembling
14. Unable to communicate
15. Bump into furniture
16. Become withdrawn
17. Unable to recognize own body parts
18. Difficulty rising from chair
19. Forgets names, phone numbers, directions, conversations, events
20. Rapid emotional changes
21. Forgets to complete a task
22. Listless
23. Makes up stories
24. Outbursts of temper
25. Changes in appetite
26. Disturbed sleep patterns and wandering
27. Difficulty with new or unusual tasks
28. Dependent on others
29. Delusions or hallucinations
30. Delirium
31. Ignores rules of conduct
32. May appear confused
33. May be able to read not understand
34. Unable to recognize pain

EXERCISE #3

MAKING A TELEPHONE CALL

OBJECTIVE:

To sensitize participants to the relationship between declining cognitive abilities and the ability to carry out simple tasks.

METHOD:

Participants are instructed to imagine that they have the responsibility for teaching a newly arrived immigrant to this country how to make a telephone call. This person has never before seen a telephone and has a limited understanding of the English language. Participants may work individually or as a group. In the time allotted, they must develop and describe their plan, outlining all of the steps involved.

DISCUSSION:

Several points should be emphasized during this exercise.

1. Participants will have a greater appreciation of the number of separate and different steps involved in making a telephone call. Tasks which are done almost unconsciously are actually far more complicated than they seem and do require cognitive abilities that are taken for granted.

2. Compare the ability of the immigrant to only understand some of the words spoken to him to the experience of the Alzheimer's victim who has lost the ability to understand the meanings of once familiar words. What did the participants do to try to help the immigrant understand? Would any of these techniques work in communicating with the patient who is suffering from Alzheimer's Disease?

3. Refer to Reisberg's theory of reverse cognitive development as it applies to the person with Alzheimer's Disease. Ask the group to now consider teaching a six-year-old how to use the telephone. Is it possible? If so, how would they do

it? What would have to change from the way they taught the adult? What if they were to teach a two-year-old how to use the telephone? Is this possible? Do they have the intellectual and cognitive ability to carry out this task? Can any comparisons be made to the person with Alzheimer's Disease whose functional abilities are those of a young child or toddler? Do expectations and caregiver approaches need to change as the disease progresses?

4. Encourage the group to discuss what it must feel like to not be able to remember how to do the simple tasks they have done all of adult lives. Studies done with Alzheimer's victims indicate that the feeling of shame and humiliation remain with the person long after other cognitive abilities have been lost. Thus, while some of the actions and abilities of patients may resemble those of young children, they are sensitive to the manner in which they are regarded. They need to be treated as adults with some limitations, not as children. The group may also wish to discuss what factors get in the way of their doing this.

TIME: 20 - 25 minutes

EXERCISE #4

ACTIVITIES FOR RESIDENTS WITH ALZHEIMER'S DISEASE

OBJECTIVE:

To provide participants with an opportunity to explore meaningful activity options for residents suffering from Alzheimer's Disease.

METHOD:

Participants are separated into small groups. Each group selects a resident from within the facility who carries a diagnosis of Alzheimer's Disease. The group is encouraged to share among themselves their knowledge about the resident's previous occupation, hobbies, interests, and skills. Participants are encouraged to discuss how these activities could be modified to a degree which would be meaningful to the resident.

DISCUSSION:

The following ideas should be highlighted in the discussion:

1. Persons with Alzheimer's Disease are able to retain long used skills for a greater length of time. The carpenter will remember how to sand a piece of wood even when he gets lost going to his room. The business woman may feel comfortable sitting in a resident council meeting long after she has lost the ability to complete personal care needs. Activities involving previously learned and overused skills may be a source of great comfort to the resident, and through him, the staff.

2. Many persons who work with people with this disease stress the importance of encouraging meaningful activity for people. They believe that at some level, the victim knows the difference between meaningful and busy work activities. They also maintain that staff will regard the person in a different light if they see them doing meaningful activity.

3. Activities will need to be continually monitored and modified as the disease process progresses and the person's abilities change (refer to accompanying chart).

For example, the person who enjoyed playing cards all of his life may still enjoy activities that involve the familiar object and skill - cards. As the disease progresses, the person may move from being able to play simple card games with assistance to being able to separate cards into colors. Even though the ability has changed, the activity still involves the familiar object, cards.

TIME: 25 - 30 minutes

EXERCISE #4 - ACTIVITIES FOR RESIDENTS WITH ALZHEIMER'S DISEASE

MODIFIED ACTIVITIES FOR ALZHEIMER'S PATIENTS

ACTIVITY: Card Games

STAGE 4: Patient can still play cards, chess and checkers with subtle reminders.

STAGE 5: Patient can play simple card games, such as War, Old Maid, or Concentration, using half a deck of cards.

STAGE 6: Patients can match up playing cards according to color or suit. Patient can separate checkers by color and match them to corresponding colors on a checkerboard.

ACTIVITY: Painting, Drawing

STAGE 4: Patient may need assistance only with setting up work area or cleaning up. Crayons will usually be perceived as too childish at this stage.

STAGE 5: Patient can draw or paint concrete objects, e.g., vase of flowers rather than abstract designs. Limit choice of colors to four.

STAGE 6: Using only one color at a time, patient can fill in different shapes that therapist has drawn. Patient can identify shapes and colors.

ACTIVITY: Knitting, Crocheting

STAGE 4: Patient can follow a pattern that is simple and repetitive. Limit number of colors used.

STAGE 5: Patient can knit or crochet small squares of different colors. Help patient put these together to form a placemat. Plastic knitting needles may be used for safety.

STAGE 6: Patient can wind skeins of yarn into balls (this is very repetitious). Discuss what each color reminds patient of.

ACTIVITY: Ceramics, Clay Work

STAGE 4: Patient may prefer to copy objects rather than create "originals," Supervise clean-up process.

STAGE 5: Patient can make simple clay shapes, forms, letters; make impressions in clay with fingernail, fork, penny, toothpick, etc.

STAGE 6: Give patient nontoxic clay, such as Play-Doh, to encourage tactile stimulation. Discuss textures and colors.

ACTIVITY: Exercise

STAGE 4: Patient can follow along with exercise programs on television. Encourage patient to walk outside as often as possible.

STAGE 5: Do structured exercises with patient at a set time each day. Reinforce body parts and their relationship to one another.

STAGE 6: Patients can exercise by following directions. Encourage body awareness in relation to external environment.

ACTIVITY: Horticulture, Gardening

STAGE 4: Offer simple reminders to help patient maintain independence, e.g., sign near plants noting which days they need water. Keep watering can near plants; garden.

STAGE 5: Patient can water plants/garden with assistance and supervision. Offer praise and reinforce that patient is caring for something alive. Supervise use of toxic plant foods.

STAGE 6: Patient can arrange cut flowers, with supervision, in a nonbreakable vase. Have patient smell flowers, feel textures, and describe colors.

ACTIVITY: Museums, Art

STAGE 4: Patient will enjoy museums and art shows. Discuss art works on the way home. Buy a program from each show or exhibit to stimulate memories.

STAGE 5: If patient cannot tolerate museums, use art books. Have patient discuss favorite artists or favorite style of painting.

STAGE 6: Using art or photography books, have patient describe pictures How many people in picture? what season does it look like?).

ACTIVITY: Photography

STAGE 4: Choose a subject and have patient photograph with an instant camera. Put photos by subject in an album and date them.

STAGE 5: Help patient organize a photo album of his favorite places, vacations, etc. Discuss subject matter and try to evoke positive memories. Attempt to date all photographs.

STAGE 6: Arrange photos of family members, patient and aide/nurse with whom patient has frequent contact. Label each photo with subject's name and relationship to patient, e.g., Bob-son, Susan-niece, Bill-brother. Discuss memories about each person.

ACTIVITY: Stamp Collecting

STAGE 4: Patient may enjoy stamp or coin collecting. Focus on a particular country or subject, e.g., flowers on stamps.

STAGE 5: Patient can place large colorful stamps in a photo album. Use only a few (four to five) stamps at a time.

STAGE 6: Patient can sort out stamps according to size, color, or shape. Use stamps with very light cancellation marks or mint stamps.

ACTIVITY: Reading (newspaper, magazines)

STAGE 4: Patient is able to read with good understanding but may have trouble concentrating. May be advantageous to obtain large-print newspapers or condensed versions of books and articles.

STAGE 5: Discuss news stories with patient and have him or her relate current news events to past news events. (Who was the last President you voted for? How much was bus fare when you were working?)

STAGE 6: Reading comprehension will be very limited. Have patient look through colorful magazines or catalogs, perhaps choosing a favorite picture and discussing it.

ACTIVITY: Pet Therapy

STAGE 4: If the patient has a pet, encourage this relationship and offer positive feedback that the patient is caring for something that is helpless and needs the patient's assistance to survive.

STAGE 5: Patient may still be able to care for and feed a pet with close supervision. Encourage other activities that involve animals, e.g. painting animals, examining photographs and drawings of animals.

STAGE 6: Permit supervised interaction with an animal. The more confused patient will still respond to a living thing in his environment.

FROM: AJN, February, 1984, Reisberg, Barry, M.D., "**Stages of Cognitive Decline**."

HANDOUT #3

DO YOU
REMEMBER LOVE

Do You Remember Love

A friend of ours once told us, "Do not go gentle into that good night"...and, my friends, I have tried to rage against the dying of the light. But now my rage is long since spent. Not squandered, nor even proudly laid upon the bar, but given out grudgingly to a dark, unseen creditor who drags me into the darkness for debts I do not remember. But, my dearest love, I would not let him drag you with me, for our love was not a dying thing. It was, and is, a gift of life. So live, live well, and live for me.

Day by day I feel myself sinking slowly down the funnel of a silent cyclone whose edges only spin me when I try to climb out, or dream myself out of this. I fear you have lost me as I have lost myself. Yet I am the lucky one. For I shall not know the end when it presents itself. So you will suffer for me. Nobody ever said life was fair.

Don't be afraid to laugh, because it is the one thing we have that is ours alone. Our one pure invention. Use it when you think of me. Do not cry for me. I've lived better than anyone I know. I've had the rare chance to say every damn thing I ever wanted to say. And people listened.

And although I have forgotten many things, I do still remember love. I have loved my life. And I have been loved. Loved in a way that we only dream of being loved. Loved by my husband, my child, my parents and by you. As laughter is our purest invention, love is our purest gift. I would like to now return the gift. So all I want to say is...I love you.

FROM: ADRDA Newsletter, **Alzheimer's Disease and Related Disorders Association, Inc.**, Chicago, Ill., Fall, 1984.

Concluding speech from the movie, **Do You Remember Love**.

SECTION B

BEHAVIOR

CONTENT:

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BEHAVIORAL PROBLEMS

AND THEIR MANAGEMENT

Background Information:

Management of the difficult dementia patient generates a high degree of frustration among nursing and boarding home staff. This fact was emphasized in a recent study published in the American Journal of Alzheimer's Care and Related Disorders. The study, which analyzed the impact of difficult dementia patients on health care staff, revealed that those who work most directly with patients are usually poorly trained. Because their understanding of Alzheimer's Disease and other dementias is so limited, they tend to use management strategies that are successful with patients who are more cognitively intact. The same strategies, however, are not effective with the mentally impaired, and their utilization with dementia patients most often leads to management failures, staff frustration and burnout, and inappropriate patient care.

In this section, management strategies for patients who suffer from Alzheimer's type dementia are discussed. Those behaviors identified by caregivers as being most common are the focus. Also, management techniques proven to be successful with difficult patients will be addressed.

In the July/August, 1987 issue of the **American Journal of Alzheimer's Care and Related Disorders**, a study was published entitled "Managing the Difficult Dementia Patient: The Impact on Untrained Nursing Home Staff." The study endeavored to analyze the difficult dementia patient and determine:

1. The behavioral problems most commonly encountered by caregivers
2. Effective management techniques
3. The impact on staff

In this study, staff from a large nursing facility were asked to identify patients whom they considered to be difficult to care for. Trained interviewers asked caregivers a series of questions relating to their patients, experiences and feelings. In this discussion some of those questions are considered.

Note to the Instructor: As each survey question is given, the instructor may wish to discuss the group's reactions before discussing the actual survey results.

QUESTION #1

WHEN, IN THE COURSE OF THE DAY DO YOU EXPERIENCE MOST BEHAVIORAL PROBLEMS?

The study revealed that most behavioral difficulties were encountered during the A.M. shift, usually concerning such activities as bathing, toileting, dressing, feeding, turning, or giving medications.

To successfully accomplish these activities, there must be a clear understanding of ideas and intentions. In other words, all of these activities involve communication. It is believed that much of the difficult behavior with dementia patients can be attributed to the communication changes and losses which accompany progressive dementia. Often, certain ideas or phrases are fixed in the patient's thinking. They lose the ability to process and understand the complexities of normal conversation. It would be helpful for caregivers to understand two facets of the communication problem: language loss and concept loss.

Language Loss

Among Alzheimer's patients, the ability to use nonverbal language is listed as one of those skills that is retained the longest. This means that long after patients lose the ability to process verbal communication they remain sensitive to the emotional messages that are sent through body language, voice tone, and facial expression.

Noted researchers Hoffman, Platt, and Barry have shown that "Patients smiled and reacted positively to a warm smile, a friendly voice tone, and gentle hand clasp. However, they were startled and upset by a stern face, an impatient voice tone, and a firm clasp on the wrist."

> **Note to the Instructor**:Listed below is a list of communication tips for working with the demented patient. This is by no means an exhaustive list and the instructor may want to discuss these and other strategies that are included in the handout material.

Avoid using "wordy" sentences. Introduce yourself by name, "I am Joan, Mrs. Akers. Let's eat now."

Speak clearly, slowly and in a soft voice. Be patient and give the person plenty of time to respond.

When communicating, eliminate as much noise and other distractions as possible (Radio, TV, crowds, etc.).

In most long-term care settings caregivers try to promote independence and let patients make their own decisions whenever possible. However, in the case of the Alzheimer's patient, it is better to limit the decision making. Avoid asking "why" or "do you want to?" questions. Often, out of frustration, we implore, "Mr. Smith, why won't you do this?" Now Mr. Smith must process the question and search for words he cannot find. His inability to express himself frustrates him. This type of interchange usually results in the patient using avoidance responses which frustrate even further both patient and staff.

Send a lot of positive nonverbal messages. Patting, gentle touching, smiling, nodding approvingly. All of these help the patient feel secure and appreciated.

Patients tend to feel less threatened if you sit or kneel to avoid standing over them.

Concept Loss

In one experience, we read of a patient who became extremely apprehensive, even combative, each time staff attempted to give him a shower. On one occasion, the patient exclaimed, "Don't put me in there, it's raining." The patient had totally lost the concept of a shower, and he could only associate the falling water with rain. How frightening and confusing this must have been. Why were people trying to put him in a room where it was raining?

We may encounter similar behaviors when caring for or attempting to engage a patient in a certain activity. Recognizing that concept loss does occur may cue us to the possibility that the patient is perceiving something entirely different than what is actually happening.

Because it is not possible to know what a patient is thinking, caregivers need to be both patient and inventive when working with people who have progressive dementia. Ask yourself, "How important is it that this be done right now?" or, "Can I try later, perhaps using another approach?"

For interaction with the patient be as meaningful as possible, it is important to be aware of the skills that are retained longest in Alzheimer's Disease patients. These have been identified as follows:

1. **Remote memory for overlearned skills**

   This fact makes it imperative for caregivers to learn the history of the patient. A man who has been a plumber all of his life may still find meaning in screwing pieces of pipe together. One who has been a cook may still be able to perform certain tasks in the kitchen, etc.

2. **Ability to help with self care**

Because the above is true, with gentle hand-over-hand encouragement a patient might still be able to perform procedures that have become habit patterns through years of repetition. Washing hands, brushing teeth, etc.

3. **Ability to use non-verbal language**

We have already discussed the importance of this. Additional training in better non-verbal communication would benefit both patient and staff in any health care setting.

4. **Ability to enjoy social interchange**

Many Alzheimer's patients receive a great deal of pleasure in small group settings. Music and/or dancing in particular are enjoyed by these patients.

5. **Ability to walk**

The ability to walk may become one of the few ways in which patients can express themselves emotionally. Providing the opportunity to walk as often as possible will be of great value to patients in many ways. It can help muscle tone, digestion, burn off nervous energy, help patients sleep better, and provide a means of expressing needs and wants. During the final stages of Alzheimer's Disease patients will become bed ridden.

6. **Ability to express appropriate feelings**

If a male staff walks into a room where a female patient is uncovered, she may blush and try to cover herself. Adult feelings that become part of us all, fear, embarrassment, shame, etc., are still retained in the patient. This should serve as a reminder to us that one of our primary roles is to protect and preserve the dignity of those for whom we care.

QUESTION #2

HOW ARE THE PATIENTS DIFFICULT? WHAT BEHAVIORS DO YOU ENCOUNTER THE MOST?

The breakdown in this particular home ran as follows:

31% Included demanding types of behavior. Constantly wanting attention, repeating phrases or questions, following staff around, crying or moaning

24% Being verbally abusive, yelling, being threatening or noisy

19% Being physically assaultive, throwing things, kicking, hitting

18% Uncooperative, resisting treatment, curling in a ball

8% Included confused behavior, wandering, incontinent, having a language barrier

Much of the on-the-job stress experienced by those who care for Alzheimer's patients is attributed to unpredictable behavioral responses. A patient standing quietly in his room may suddenly strike out when approached. In the dining room a woman suddenly begins yelling or crying uncontrollably.

This type of behavior is most often attributed to what is termed as "catastrophic reactions." This is a term used to describe what happens when a situation so confuses or frightens a patient, that it overwhelms his ability to control his emotional distress.

Who has not experienced the urge to "clobber" someone, to tell this or that person just what is thought? Fortunately we are able to control those impulses. In the progression of Alzheimer's Disease however, that portion of the brain which enables control over impulses is being destroyed. Thus a patient may exhibit an excessively strong reaction to a very minor incident.

Catastrophic reactions in a health care setting might be caused by any of the following.

1. A crowded or noisy environment
2. Small accidents, spilling water or dropping food at the dinner table
3. Abrupt, tense or impatient staff
4. Forgetting how to complete a task. The patient is buttoning his shirt at the third button and simply forgets how to proceed.
5. Strange surroundings, a lot of strange faces
6. Being hurried or asked too many questions - being scolded

HELPING STRATEGIES FOR CATASTROPHIC REACTIONS

1. Maximizing Distractibility

This is one of the most important strategies for caregivers to be acquainted. Here, the patient's forgetting can work to your advantage. Often a brief distraction such as, "Mr. Smith look at those beautiful flowers," or "Here, would you like a glass of water?" will be enough for the patient to forget why he was upset.

Patients on occasion have grabbed the clothing or wrist of a caregiver. The immediate reaction is to pull away and demand that the patient let go. This urging usually increases the anxiety as well as the patient's inability to release his grasp. In this situation a caregiver might pick up another object, a book, a glass, etc., handing them to the patient say "Mr. Smith, here, take hold of this." The patient will usually release his grasp and reach for the new object.

2. **Do not restrain a patient during a catastrophic reaction**

You will only escalate his behavior. Back away, be mindful of your voice tone and body language, keep calm.

3. **Remember communication techniques**

Give slow, one step at a time directions. Lower voice. Use gentle touch or patting.

The following have been identified by caregivers as the most common behavioral characteristics of people with Alzheimer's Disease.

Rummaging, Pillaging, Hoarding

Those who work in long-term care facilities usually have no difficulty identifying a patient who constantly wanders into other persons' rooms, rummages through their drawers, takes and hoards clothes or other objects that doesn't belong to him/her. This type of behavior can be a constant source of frustration for the caregiver. Patients do not perceive themselves as doing something wrong and will not respond to moral admonitions, "How could you take poor Mrs. Brown's book? You should be ashamed." Yet may Alzheimer's patients seem driven to wander and search. Some have suggested that they constantly search for something familiar. Dr. Judah L. Ronch, a psychologist who is a consultant to the Fishkill Health Related Center in Beacon, NY, relates the following experience. Dr. Ronch was asked to help the staff with a patient (Molly) who was constantly "invading everyone else's space and belongings." His initial intervention was to ask a simple question. "Why do you constantly walk all around this place and go into other peoples' rooms?" Dr. Ronch states, "Her reply helped me to understand how dementia feels to the patient.

She said:

> "I look for Molly and I can't find her. I used to be able to read and enjoy myself, and I'd discuss what I read with other people. But now I read and I don't remember what I

read. That's not me, not the real Molly. So I walk around looking for Molly, but she's nowhere to be found."

Since this behavior seems to hold some purpose, have a place with a box full of different objects, perhaps in a special room where the patient can rummage and search.

Here again the staff might use distraction to divert the patient's thoughts in another direction.

Wandering:

As we have previously mentioned, walking may become one of the few avenues through which feelings, wants, and needs can be expressed. Therefore, if a patient begins to wander excessively, you may want to determine if the patient is wandering because:

1. His clothes are too tight?

2. He needs a bathroom?

3. Is hungry?

4. Is constipated?

One large facility told us that one of the most common reasons for wandering among their AD patients was constipation, and when this problem was addressed, the wandering was significantly reduced. This is an understandable problem, as AD patients often do not drink enough or get adequate exercise.

Patients may wander because they feel lost and are searching for something familiar. When every room and corridor looks exactly the same a patient might search futilely for their own room. Some facilities color code different wings to make it easier for patients to orient themselves. Many wanderers may simply be going "home".

There are a number of alarm devices which can be worn by patients who are inclined to wander off. Some facilities have installed full length mirrors by the doors so that the resident is distracted by his own image.

Being allowed to walk can benefit the resident in ways described earlier. It is good, therefore, to allow the patient to walk as much as possible. Many facilities, designed for the care of the demented patient, have a corridor which usually extends around the inside periphery. This provides a "walking track" residents sometimes utilize for hours at a time. Patients are provided with good walking shoes and even jogging outfits.

Diminished Vision and Depth Perception

This adds still another dimension to the difficulty of AD patients. One facility told of an AD patient who continually voided in the bathroom waste basket. Recognizing that everything in the bathroom was white except for the dark brown waste basket, they decided to change the color of the toilet seat. This solved their problem.

Problem Solving

When faced with periodic outbursts or other difficult behavior, try meeting with other caregivers who work with the resident for a brainstorming session. Discuss the following questions.

1. **What is the emotion being displayed?**

   Frustration? Anger? Fear? Try to understand the resident's reaction. Put yourself in his/her shoes.

2. **When does the problem occur?**

   Compare notes with other caregivers. It can be helpful to keep a log and record problems that come up each day. You may begin to see a pattern in terms of the time of day or some triggering event.

3. **What triggers the problem?**

   A particular person? Need to go to the bathroom? Tight clothes? Hunger? Commotion? Darkness? Any environmental changes that would lessen the problem?

4. **Be creative. Discuss different approaches.**

   Don't worry about failing. Your not failing if something doesn't work--you're gaining new information. Keep trying different things.

5. **Remember the progressive nature of this disease.**

   Review, **"Stages of Cognitive Development"** (included as handout #2, in the first section of this module). Staff often resort to **Force, Coercion,** or **Threat** which leave them feeling depleted and guilty. Recognizing that Mrs. Smith is functioning at the level of a five-year-old will help staff relate to the patient more appropriately. Suggested reading, **"Just As You Are"** included in handout material.

EXERCISE #1

BEHAVIOR MANAGEMENT TECHNIQUES

OBJECTIVE:

To increase participants' understanding of patient behavior and to improve their abilities to implement effective behavior management techniques.

METHOD:

Participants are divided into small groups of 3 or 4. In an ideal situation all three shifts are represented in this activity. Each group selects a resident whose behavior is difficult. A secretary should keep a record of each group's discussion which includes the following:

1. The types of behavior encountered.
2. When does the behavior usually occur?
3. Management strategies used.
4. The effectiveness of the intervention
5. Suggestions for resolving the problem

DISCUSSION:

1. Are the same behaviors encountered on each shift?
2. Do all staff use the same type of intervention?
3. What are the differences and similarities around each incident? Is the same resident or staff person always involved?
4. Based on accumulated information, can the group suggest new ideas or approaches that might be tried? Can we work more effectively as a team on this problem?

It may be found that the discussion following the group activities can open a beneficial dialogue between caregivers and help develop a greater sense of team. This kind of "brainstorming" might also serve to resolve long-standing problems.

TIME: 20 - 25 minutes

HANDOUT #1

THE FOUR "R'S" OF PROBLEM SOLVING WITH DEMENTIA

RECONSIDER

Ask:

DOES THE BEHAVIOR PLACE ANYONE AT RISK? WHO IS AFFECTED BY THE BEHAVIOR?

RECHANNEL

SUBSTITUTE ANOTHER MEANS OF DOING THE BEHAVIOR. TAKING FOR A WALK FOR WANDERING.

REFOCUS

TRY TO FOCUS PATIENT'S ATTENTION ON SOMETHING ELSE. DON'T ARGUE. A BOX TO RUMMAGE IN, IN PLACE OF OTHER RESIDENTS' BELONGINGS.

REDECORATE

KEEP ENVIRONMENT SIMPLE. USE CONTRASTING COLORS TO HELP DEPTH PERCEPTION.

"JUST AS YOU ARE"

Since my father's death two months ago, everything has overwhelmed me. There are so many things to deal with - so many bills, so many decisions, so many feelings. And then there's my mother.

My mother has Alzheimer's disease. She is growing progressively more confused and unable to take care of herself. My dad devoted the last two years of his life to caring for her. He cooked, cleaned, bathed her, and even saw to it that she got her hair done. Now I have come to Florida to stay with Mama and do these things for her.

But I can't get used to seeing my 74-year-old mother behave like a three-year-old....

We are standing at the checkout counter in the supermarket. The clerk is bagging our groceries, and my mother is busily taking a handful of candy bars from the display rack. She shifts restlessly from foot to foot, back and forth.

"Don't do that, Mama," I say to her, my voice strained. "And please stand still. Everybody's looking at you."

Suddenly she heads for the exit. "Where are you going now?" I grabbed her hand and pulled her back to my side. "Now stand right here until I finish paying." It's all I can do not to grab her by the shoulders and shout at her, "Mama! You know how to behave. Stop acting like a child!"

And then I'm angry at myself. After all, she can't change her condition by an act of will.

As we drive home in the car, my thoughts fasten obsessively on my mother. She won't do anything I ask. I can't get her to eat. She naps all day and wanders about the house all night. I sleep on the couch so as to catch her when she walks by, which means I don't really sleep, I doze. I give her the tranquilizers the doctor prescribed but feel they should have been for me. I have even bought megavitamins for her, hoping against hope to bring her memory back by improving her nutrition.

Throughout this time I've been impatient, frustrated, and resentful. I'm not accustomed to telling my mother what to do; it doesn't feel right. Until now she had always been the one in charge. I don't know how to act anymore - and so I react. I scold her as if she were a naughty child.

"Don't go to sleep now, Mama." "Sit down and eat your lunch." "Get up, Mama." "Stay awake." "Go back to bed." What more can I do? I'm doing everything in my power to force her to act as normal as possible.

And then I hear what I'm saying: "...everything in my power to force her..." Power, force, coercion, threats: "Do this!" "Don't do that!" What a picture that makes. And it certainly isn't working. Even the simplest daily task has turned into a tug-of-war: my will against hers. What am I accomplishing in this power struggle? Can I alter the course of her disease through the sheer force of my will? If not, what is my goal?

What I have been doing has not been much help. It seems, in fact, most unhelpful. I'm cross and oversensitive, and my mother in constantly on the defensive.

At home I persuade Mama to lie down. I put on one of the tape cassettes of hymns that seem to please her. After a while I find myself humming along with a hymn from my childhood, "Just As I Am". I can't remember all the words, but the refrain keeps repeating in my mind: "Just as I am. Just as I am."

Not "as you'd like me to be." "Just as I am." Right now, not yesterday or last year. "Just as I am." Here and now.

And suddenly I'm aware that the one thing I haven't done for my mother is see her, really see her, just as she is. I've been looking at her in the same way that I've looked at her since I was a teenager, seeing her as a person who's strong, capable, hardworking, confident, in control. I've been so busy chasing ghosts from the past that I have not made any effort to relate to her just as she is: confused, frightened, alone.

I feel a hand on my shoulder. Mama is standing next to me, a big smile on her face. "Hi, honey," she says.

"Hi, Mama, what's up?"

"Just me," she replies.

"That's wonderful." I turn and give her a hug.

"What was that for?" she asks.

"Just for you," I answer. "Just for you being you."

"I'm tired now. I think I'll take a nap." She walks over to the couch, makes herself comfortable and shuts her eyes.

I know now what I need to do. In order to heal my relationship with my mother, my first priority is to remove the past from our present.

It isn't easy. Many times I find myself slipping into old patterns, but the results are worth the effort.

I stop trying to get her to admit that she is confused. If she believes that she still does all the cooking and cleaning, so what? It's a harmless belief, and it helps her maintain her sense of dignity. When she asks for her mother or someone else long dead, I answer gently, and she looks at me and says, "My mama's dead, isn't she?" I nod yes. "I thought so," she says, shaking her head slowly and returning to her place on the couch.

I let go of my "remembered mother" and begin struggling to see the mother right here in front of me. I drop my expectations and allow her the freedom to be old and confused. I stop myself from saying or thinking anything that implies she is not doing her best. She no longer needs to defend herself, and our tug-of-war over meals and sleep end.

Mother doesn't change. She doesn't stop sleeping all day and roaming about the house all night. She doesn't stop marching in place whenever she has to stand for more than a second. She doesn't stop needing constant care and attention. What changes is how I respond to her. I open my heart and my arms, and begin to see not her stubbornness but her innocence, not her confusion but her vulnerability. And I see that she is truly doing her best.

I stop trying to force her to be what she can no longer be. In so doing, I give her the freedom to be wholly who she can be. And she becomes like a child again: trusting, open, loving, living out her life at peace, just as she is...

I am standing at another checkout counter, putting back the things my mother keeps removing from the display rack. She smiles at me. It has become a game to her. I smile back. She is my mother and I love her.

"Mama, you are a scamp." I tease her gently.

"I know." She grins.

"I love you, Mama."

"I love you, too," she answers.

FROM: Good Housekeeping, March, 1989. Written by Virginia Sheeley Dustin

HANDOUT #2

COMMUNICATION TIPS

- The tone of your voice and facial expression are as important as the actual words spoken. Alzheimer's patients can be sensitive to non-verbal communication.

- Speak slowly and simply. Do not expect a quick response. Give the person time to process the information.

- Understand that the Alzheimer's victim may say one word and mean another. You may have to guess at the correct meaning. Try to clarify your guess with the person. You could be wrong.

- Stand in front or in the direct line of vision of the person. Touch an arm or shoulder gently to get or keep attention. Sustain eye contact.

- Do not startle by approaching from behind.

- Use gestures and visual cues or aids to get across your messages. Try using more than one of the senses to communicate, such as touching as well as talking. Do not use gestures that threaten the person.

- If it is necessary to repeat statements, use the same words. Do not rephrase sentences or use different words. You may wish to ask the person to repeat what you have said. This may help the person to understand.

- Present only one idea at a time. Do not try to give too much information in one sentence.

- Discuss only concrete actions and objects. The person cannot relate to abstract concepts.

- Communicate with the person as much as possible, although a constant stream of conversation is neither helpful nor necessary.

- Avoid questions whenever possible, such as quizzing the person on names of family members. Not knowing the answers embarrasses the person. It may be helpful to cue the person with the necessary information, such as supplying names.

- Use short sentences, giving simple messages.

- Do not offer choices that make decisions difficult, or that are not acceptable to you.

- Use direct statements to initiate action, such as "It's time to take a bath," or "Let's get dressed now."

- Use a normal tone of voice, in a calm manner. Do not express excitement in your voice.

- Use humor when possible and appropriate.

HANDOUT #3

CATASTROPHIC REACTIONS

A catastrophic reaction is an over-reaction to minor stress. It is important to recognize when this is happening with patients with dementia. The early warning signs are:

FLUSHING

RESTLESSNESS

REFUSALS

STUBBORNNESS

Precipitating Events:

MISINTERPRETATION OF REQUEST BY SOMEONE

MISINTERPRETATION OF SENSORY INFORMATION

COGNITIVE OVERLOAD

INABILITY TO PERFORM A TASK

FATIGUE

It is important that these signs be recognized when they start. Rather than trying to force the issue, return to the resident later and try again.

HANDOUT #4

WANDERING

Wandering

- When a confused person becomes disoriented and lost, he may feel frightened.
- Wandering may result in getting lost
- New environment may lead to wandering
- May wander for no apparent reason
- Continuous pacing and wandering can cause feet to swell
- May be way of communicating feelings of restlessness, boredom, need for exercise. May be upset.

REMEMBER THIS IS NOT A BEHAVIOR THAT THE PERSON CAN CONTROL

Interventions

- Reassure often of whereabouts
- Take for a walk each day
- Surround with familiar things
- Ask yourself what may be causing catastrophic reactions (agitated pacing)
- Does it happen at the same time each day?
- Does the response of others to wandering cause it?
- Create calm environment
- Place night lights in bedroom to help decrease confusion. May misinterpret what they see at night.
- Speak softly and quietly, soft radio playing.

FROM: The 36-Hour Day, Nancy L. Mace and Peter Rabins, M.D.

HANDOUT #5

HAZARDS FOR CONFUSED PATIENTS

- Many over-react to mishaps, allow to calm down
- Cannot remember
- Check regularly for possible hazards
- Keep environment neat and uncluttered
- May forget what can and can't be eaten
- Never leave alone in a car
- Smoke only with supervision

Eating problems

- May hide food and eat later after it has spoiled. Throw food away
- New foods may confuse patient
- Forget to eat
- May refuse to eat certain foods
- May forget they have just eaten

Interventions

- Give nibbles and finger foods
- Keep confusion down in eating area
- Check dentures
- Place only utensil used at place, use bowls (easier than plates)
- Place damp washcloth under plate to prevent sliding
- Don't fill glasses and cups too full
- Limit number of foods at one time

- Cut food before serving
- May need to remind to chew and swallow
- Guard against choking
- Should always sit straight when eating and for 15 minutes after
- Do not feed person who is agitated or sleepy

FROM: **The 36-Hour Day**, Nancy L. Mace and Peter Rabins, M.D.

HANDOUT #6

BEHAVIOR PROBLEMS

Behavior Problems with Confused Persons

- Problems may worsen in the evening when tolerance for stress is lower. YOU MAY ALSO BE MORE TIRED DURING THE EVENING.

- Losing and Hiding. To reduce problem, keep room neat. Check wastebaskets, under mattresses, sofa cushions, etc.

Inappropriate Sexual Behavior

- May undress or expose themselves, forgetting where they are or where the bathroom is.

- Masturbation in inappropriate environment may be part of brain damaged behavior. Does only what feels good, forgetting social manners.

Interventions

- Do not over react, return to room or bathroom.

- Do not act upset, lead gently to a private place.

- Distract, give something else to do.

FROM: **The 36-Hour Day**, Nancy L. Mace and Peter V. Rabins, M.D.

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DEMENTIA

OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION A			
To review the differences between causes of reversible and irreversible dementia	Exercise #1 Living with Grace	Film and Group Discussion	35-40 minutes
	Exercise #2 Behavior Changes related to dementia	Group Activity and Discussion	15-20 minutes
To discuss the relationship between brain function and irreversible dementia	Exercise #3 Making a telephone call	Group Activity and Discussion	20=25 minutes
To review the stages of cognitive decline in Alzheimer's Disease and their relationship to care planning	Exercise #4 Activities for Residents with Alzheimer's Disease	Group Activity and Discussion	25-30 minutes
SECTION B			
To discuss communication needs of the resident with dementia and interventions for enhancing them	Exercise #1 Behavior Management	Group Activity and Discussion	20-25 minutes
To identify the most common troubling behaviors associated with dementia and interventions consider helping interventions			

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HANDOUT #

FRONT

BACK

MOTOR AREA

SENSORY AREA

BROCA'S AREA

WERNICKE'S AREA

AUDITORY AREA
LANGUAGE

VISUAL AREA

KEY TO DIAGRAM OF BRAIN

SELECTED AREAS OF FUNCTION

1. Skilled Movements
2. Judgement
3. Activation
4. Creative Thought
5. Writing
6. Intellect
7. Attention
8. Personality
9. Reflection
10. Emotional Reaction
11. Bodily Reaction
12. Fear
13. Verbal (Speech)
14. Reading
15. Memories
16. Auditory Memories
17. Visual Memories
18. Musical

GERIATRIC EDUCATION & RESOURCE OUTREACH

UNIT #6

COMMUNICATION

UNIT #6

COMMUNICATION

Communication in the health care setting is a most critical and continuing issue. Unit #6 has been developed to serve as a basis on which future communication skills can be developed.

Section A is a generic overview of the basic elements of communication. Section B follows with a look at the role of stressors in the health care setting as factors in communication breakdown. Section C emphasizes the role of the listener in the communication process, and provides opportunities for participants to enhance their listening skills.

OBJECTIVES:

Section A	To discuss the role of effective communication in relationships.
	To review the components of the communication process.
	To discuss "blocks" to effective communication.
	To review the role of perception in the communication process.
Section B	To discuss the role of interpersonal stressors as they affect communication in the health care setting.
	To identify situations in which interpersonal stressors interfere with communication effectiveness.
Section C	To define the role of active listening in the communication process.
	To practice basic listening skills.
	To discuss and demonstrate four basic helping skills.

CONTENT:

Section A -Communication pp.1-17

Section B - Interpersonal Stressors pp.18-24

Section C - Listening Skills pp.25-42

SECTION A

COMMUNICATION

CONTENT:

Background Information ....pp. 2-4

Handout #1 - Believe it or Not ....pp. 5-6

Handout #2 - Characteristics of a Relationship ......pp. 7-8

Exercise #1 - Interface in Communication ....pp. 9-10

Handout #3 - Common Errors in Interpersonal Communication ....pg. 11

Handout #4 - Attitudes Communicated Nonverbally ......pg. 12

Handout #5 - Communication Stoppers ....pg. 13

Exercise #2 - Perception ....pp. 14-15

Handout #6 - Factors Influencing Observation and Perception ....pp. 16-17

COMMUNICATION

Background Information:

Often the most powerful tools are those which are taken most for granted. If you were to consider every situation that can and often has gone wrong between people, ineffective communication of one kind or another was responsible. Conversely, anything that goes right between people is a direct or indirect result of effective, positive, and helping communication. Whole nations rise and fall, fortunes are made and lost because of the way in which we communicate.

Why is it, then, when we begin to talk about "communication skills," heavy sighs and audible "ho-hums" are evident? Probably because we have been communicating since the moment of birth, believing that we are doing a pretty fair job. When problems do arise because of how we communicate, we generally hold others responsible: **they** didn't listen, **they** don't understand, **they** always have to have their own way, etc. Since this is the way in which we have always done it, it must be the right way. But, like the character in Winnie the Pooh who always came down the stairs bouncing on his head (with considerable discomfort), said "Perhaps there is another way." Perhaps there is another way to communicate more effectively; communicate with **them** so that **they** and **we** can work more effectively toward common goals.

Communication in the Health Care Setting

The implications of good communication in the health care setting cannot be overemphasized. Life or death issues are often in the balance. Less dramatic, though no less important, communication can negatively affect the environment and emotional climate in which residents live and employees work.

Communication in long-term care settings can be complicated by many factors. Often, talking to residents may seem of little value because many cannot or will not respond. Those who do may want to talk about things that cause discomfort among staff. Caregivers may have to deal with such difficult questions as "Why should I go on? No one cares if I live or die." "Am I going to die?" "I'm so lonely. Why doesn't anyone come to see me?" "I'm not good for anything anymore; even you don't want to spend time with me."

Sometimes we feel inadequate to deal with those kinds of feelings. Sometimes we are trying to adjust to our own feelings about growing old, and sometimes our best efforts are ignored. Sometimes we see only minimal progress, and sometimes we see none.

Currently, staffing shortages in long-term care facilities seem to create less opportunity for effective communication. People are so busy that they talk at each other and not to each other under the most stressful situations. At a time when effective communication is needed most, it happens least. Misunderstandings lead to greater distress, the quality of patient care often declines, and staff derive little satisfaction from their work. Residents may feel more lonely, confused, abandoned, angry and anxious. This discomfort will be communicated, verbally or otherwise, creating more distress for staff. The cycle continues.

The first step toward enhancing communication, even in this negative scenario, may be taken with very little fanfare. It can begin with an understanding of the concept of EMPATHY, a concept at the core of effective communication. Empathy is the quality of thinking and feeling about a situation from another's point of view. In the communication process, empathy means that the sender of a message should first consider who will receive it even before it is formulated. What is the level of understanding of the receiver? What is the sender's attitude toward the receiver and the message? What other things might the receiver have on his mind?

For example, if you must tell a resident that you are being transferred to another floor and will no longer be caring for them, you might wish to consider the following before speaking with the resident:

1. How close is he or she to you?

2. Does he or she know the new person who will be providing care?

3. How is he or she feeling today? Physically? Emotionally?

You will approach the situation differently if she is an outgoing individual who has several friends and feels comfortable with all of the staff than if she were a quiet person who forms relationships with difficulty and has just learned that her pet cat died.

A second element in communicating more effectively is to become more familiar with your own response to certain stress-provoking situations. Each of us, as individuals, can tolerate different situations and different amounts of stress. Further, we all define our DIS-stressors differently. It takes a fair amount of honesty and self-study to recognize and acknowledge those situations. We must then take steps to either change the way in which we react, change the situation, or know when to react. This topic is discussed further in section B.

Listening is the third area in which skill building will yield great and swift reward. We at least start out with some degree of listening ability. The challenge is to move from a passive to a more active role so that our listening becomes more effective. It is probably the single most useful skill to have. It is also an easy skill to learn. The difficulty comes in applying what you have learned. Opportunities to discuss and apply these skills are offered in section C.

Another important consideration in communication is the relationship we have with the person with whom we are communicating. Relationships are always changing. Have you ever had the experience of a neighbor or friend being admitted to your facility? Perhaps you were involved socially for many years. Your relationship could have been one of sharing experiences raising children, or having coffee at the kitchen table every Saturday. Illness strikes this friend and now you are responsible for care. Ask yourself how you would feel and how you would react.

In small rural areas, we are also confronted with the task of caring for friends or family with whom we may not be comfortable. Now we have another set of feelings to deal with.

Relationships are many and complicated. Our words and body language, our tone of voice, and environment affect these interactions. We have to be constantly aware of how we communicate in these relationships. It is not easy to monitor every aspect of ourselves when we are emotionally involved as we talk or communicate with others. Relationships in and out of a facility are constantly changing, both for staff and residents.

HANDOUT #1

BELIEVE IT OR NOT

DID YOU KNOW THAT:

- Only 10% of what you communicate is through words or speech. 40% of your message is communicated through the tone of your voice, or how you say what you say. 50% of your message is communicated through body language; facial expressions and other body gestures. If people listen accurately, they will believe your tone of voice and body language over the words that you speak (if there is conflict between the two). When a co-worker asks for your help and you respond "Oh, I'd just **love** to help you," while rolling your eyes heavenward, in which manner are you communicating your feelings most accurately?

- Almost 30% of a message is lost after passing through two persons. This is reminiscent of a game that you may have played as a child. In some areas it was called "gossip." One person at one end of a row of people whispers a message into the ear of the next person. They, in turn, whisper to the next person, and so on down the line. Finally, the last person repeats aloud what he or she has heard. This would usually result in gales of laughter because the end message did not even remotely resemble the original message sent. This same process happens again and again in the real world in which we live and work. Unfortunately, the end result is rarely funny, and often tragic. Misunderstandings, bad feelings, serious mistakes, are a few of the unfortunate results of this kind of communication.

- 45% of our communication time is spent listening, yet many of us regard listening as a very passive activity. We act like a sponge, convinced that it is the total responsibility of the sender to saturate us with the message. Yet without active participation by the listener, the sender may have understood little of the message which was conveyed back. There is an old joke that illustrates how people listen to hear what they want to hear:

  > Three men were riding on a bus. One man says to the next, "Please tell me when we get to Wembly." The second man responds, "It's not Wednesday, it's Thursday." The third man chimes in "I'm thirsty too, let's go for a drink."

  A great example of how passive listening works!

* Estimates indicate that the average person can think at a rate of between 1,000 and 2,000 words per minute. Because we can only speak at a rate of 100-400 wpm, it is easy to see how a person listening may easily become bored and start thinking ahead of the speaker, either on the same topic or (and more likely) on a different one.

* One study on communication indicated that within ten minutes after a college lecture, students had forgotten 50% of what had been said. Forty-eight hours later they had forgotten 50% of that. This means that they retained only 25% of what was said. If we transfer this to our own communication situations, we can begin to understand the importance of listening skills in this area. Certainly, when it comes to the area of resident care, we want to do everything possible to assure that more than 25% of what we are saying is being received. This kind of 25% retention of communication could not only prove inconvenient but downright dangerous in the long-term care setting.

HANDOUT #2

CHARACTERISTICS

OF RELATIONSHIPS

CHARACTERISTICS OF A SOCIAL RELATIONSHIP

1. The contact is primarily for pleasure and companionship.
2. Neither person is in the position of responsibility for helping the other.
3. No specific skill or knowledge is required.
4. The interaction is between peers, often of the same social status.
5. The persons involved can, and often do, pursue an encounter for the satisfaction of personal or selfish interest.
6. There is no explicit formulation of goals.
7. There is no sense of accountability for the other person.
8. Evaluation of interaction does not concern personal effectiveness in the interaction.

===

BENEFITS OF A HELPING RELATIONSHIP

1. Identifying, stating, and reducing or resolving troublesome feelings, anxiety and stress.
2. Clarifying conflict; ordering of needs and goals.
3. Formulating a decision; sorting out alternatives and variables; gaining different perspectives; setting either short or long-term goals.
4. Clarifying and reinforcing values; determining implications or consequences of values; decisions and actions.
5. Adjusting to developmental or situational crises.
6. Changing behavior from problem producing to problem solving.
7. Achieving new insights or self-understanding and new levels of maturity.
8. Reducing psychopathology and emotional illness.

CHARACTERISTICS OF A HELPING RELATIONSHIP

RESPECTFUL - Feeling and communicating an attitude of seeing the client as a unique human being, filled with dignity, worth and strengths, regardless of outward appearance or behavior; being willing to work at communicating with and understanding the client because he/she is in need of emotional care.

GENUINE - Communicating spontaneously, yet tactfully, what is felt and thought, with proper timing and without disturbing the client, rather than using professional jargon, facade, or rigid counselor or nurse role behaviors.

ATTENTIVE - Conveying an active listening verbal and non-verbal messages and attitude of working with the person.

ACCEPTING - Conveying that the person does not have to put on a facade and that the person will not shock you with his/her statements; enabling the client to change at his/her own pace; acknowledging personal and client's feelings aroused in the encounter; to "be for" the client in a non-sentimental, caring way.

POSITIVE - Showing warmth, caring, respect, and agape love; being able to reinforce the client for what he/she does well.

STRONG - Maintaining a identity separate from the client; withstanding the testing.

SECURE - Permitting the client to remain separate and unique; respecting his/her needs and your own; feeling safe as the client moves emotionally close; feeling no need to exploit the other person.

KNOWLEDGEABLE - Having an expertise based on study, experience, and supervision.

SENSITIVE - Being perceptive to feelings; avoiding threatening behavior; using knowledge that is pertinent to the client's situation, being kind and gentle.

EMPATHETIC - Looking at the client's world from his/her viewpoint; being open to his/her values; feelings, beliefs, and verbal statements; stating your understanding of his/her verbal or nonverbal expressions of feelings and experiences.

NON-JUDGMENTAL - Refraining from evaluating the client moralistically, or telling the client what to do.

CONGRUENT - Being natural, relaxed, honest, trustworthy, and dependable. Demonstrating consistency in behavior and verbal and nonverbal messages.

UNAMBIGUOUS - Avoiding contradictory messages.

CREATIVE - Viewing the client as a person in the process of becoming, not being bound by the past, and viewing yourself in the process of becoming or maturing as well.

EXERCISE #1

INTERFERENCE IN COMMUNICATION

OBJECTIVE:

To review several of the obstacles to accurate communication between two people.

METHOD:

Using the attached supplemental handout and questions in the discussion section of this exercise, participants are encouraged to list factors that get in the way of meaningful and accurate communication. A list is provided to use as a guide, though participants usually develop a more lengthy list of their own. Use a flip chart, or blackboard, to record the answers. Participants should also discuss possible ways to eliminate some of the barriers to effective communication.

DISCUSSION:

1. Who do you feel has the most responsibility for the communication process?

   Answer: Equally responsible (50/50)

2. What "interferences" get in the way and distort the message being communicated?

   Answer: Interferences:

   * Distractions
   * Environmental noise
   * Lack of privacy
   * Personal Problems
   * Anger
   * Thinking of other things
   * Thinking ahead of the speaker
   * Different definitions of words
   * Sensory deficits
   * Tone of voice
   * Emotional state
   * Not considering the listener's level of understanding

TIME: 15 - 20 minutes.

EXERCISE #1 - INTERFERENCE IN COMMUNICATION

SUPPLEMENTAL HANDOUT

SENDER RECEIVER

INTERFERENCE

HANDOUT #3

COMMON ERRORS IN INTERPERSONAL COMMUNICATION

1. Saying "one" or "people" or "you" in expressing your point of view.
2. Asking a question instead of making a statement: "Don't you think that..."
3. Saying "I feel" to mean "I think."
4. Making a statement instead of asking for what you want or need, e.g., "I wish you were going into town."
5. In a group, talking about a person and not to him.
6. Using "I Can't" to mean "I won't" or "I don't want to."
7. Using "have to" and "should" when you mean "choose to" or "want to."
8. Not answering a question directly: "How do you feel today?" Answer, "Why do you want to know?"
9. Using words like "I guess," "I think," or "maybe" when you are sure.
10. Using "try" instead of "do."
11. Blaming your feelings on someone else.
12. Confusing interference and observation.
13. Interrupting someone when he is speaking, which usually means you aren't listening.
14. Changing the subject or "chaining," i.e., listening to just enough of what someone says to change the subject to something you know more about or want to talk about.
15. Using statements like "always" or "never" to support your point of view.
16. Confusing feedback with confrontation.
17. Rescuing by doing something for someone that he or she can do for him or herself.
18. Making judgments about a person instead of offering feedback about behavior.
19. Discounting some aspect of a situation.
20. Maintaining a position of passivity instead of actively taking responsibility for yourself and your behavior.
21. Operating from a competitive framework in which you set up win or loose, one-up or one-down situations or relationships instead of cooperating as equals.

HANDOUT #4

ATTITUDES

COMMUNICATED NONVERBALLY

Openness
Opened hands
Unbuttoned coat

Defensiveness
Arms crossed on chest
Crossing legs
Fistlike gestures
Pointing index finger
Karate chop

Evaluation
Hand to face gesture
Head tilted
Stroking chin
Peering over glasses
Taking glasses off-cleaning
Glasses earpiece in mouth
Pipe smoker gestures
Putting hand to bridge of nose

Suspicion
Arms crossed
Sideways glances
Touching, rubbing nose
Rubbing eyes
Buttoning coat-drawing away

Confidence
Steepled hands
Hands behind back
Back stiffened
Hands in coat pockets with thumbs out
Hands on lapels of coat

Cooperation
Upper body in sprinter's position
Open hands
Sitting on edge of chair
Hand to face gestures
Unbuttoning coat
Tilted Head

Nervousness
Clearing throat
Whew sound
Whistling
Cigarette smoking
Picking or pinching flesh
Fidgeting in chair
Hand covering mouth while speaking
Not looking at other person
Tugging at pants while seated
Jingling money in pockets
Tugging at ear
Perspiration, wringing hands

Frustration
Short breaths
Tsk sound
Tightly clenched hands
Wringing hands
Fistlike gestures
Pointing index finger
Rubbing hand through hair
Rubbing back of neck

Insecurity
Pinching flesh
Chewing pen, pencil
Thumb over thumb, rubbing
Biting fingernails
Hand in pockets

Ricki Fulman, New York Daily News, Tuesday, July 17, 1973

HANDOUT #5

COMMUNICATION STOPPERS

Communication stoppers are those behaviors which prevent meaningful expression and exploration of thoughts and feelings. They are the antithesis of the skills which facilitate communication.

Often what we believe to be helpful behaviors and responses are not. In fact, they can be very harmful. Research on communication styles has yielded a list of 11 basic behaviors detrimental to communication - Communication stoppers.

1.	Directing, Ordering	Telling someone what to do, giving them little or no choice.
2.	Warning, Threatening	Telling someone that if they do something, dire consequences will result.
3.	Moralizing, Preaching	Telling someone they ought to do something because it right, moral, correct, etc.
4.	Persuading, Arguing	Trying to change someone's opinion or convincing them through the use of information and logic.
5.	Advising, Recommending	Providing a person with the answers to a problem.
6.	Evaluating, Criticizing	Making negative interpretations of a person's behavior.
7.	Praising	Making a positive evaluation of a person's behavior.
8.	Supporting, Sympathizing	Trying to talk a person out of his or her feelings or to deny that person's feelings.
9.	Diagnosing	Analyzing a person's behavior and telling the person you have figured them out.
10.	Diverting, Bypassing	Changing the subject or not talking about the problem presented by the other person.
11.	Kidding, Teasing	Avoiding discussing a problem with a person by joking and making light of the situation.

Adapted from: Peer Power, by H. Gray and J. Trindall.

EXERCISE #2

PERCEPTION

OBJECTIVE:

To assist participants in understanding the role of perception in the communication process.

METHOD:

Hold the attached picture in the exercise so that all participants can see it. Ask them to describe what they see. Most people can see one of two women in the drawing. One configuration is an old woman with a large nose and protruding chin, eyes downcast, and wearing a fur coat and scarf on her head. The other is a younger woman who is looking away over her right shoulder. One can just see the tip of her nose and eye lash. Some will see one woman and others will see the other woman. A few people will be able to see both right away.

DISCUSSION:

This exercise is best used after a review of the interferences that can impede communication (see exercise #1). It highlights the notion that people speak, listen and see through their own unique and individual "perception" filter developed over a lifetime of experience.

The trainer should emphasize that people can often see the same event or even hear the same words, but attach entirely different meanings to what they see or hear. At this time, the trainer might illustrate the point with the following exercise:

Say the word "dog" to the participants in the room. Then immediately go around the room and ask each individual what image, feeling, or idea came to mind upon first hearing the word. You will get a variety of responses -dirty, pet, scared, don't like, friend, etc.

Emphasize that the word dog had many meanings to the people in the room based on what they perceived through the filters of personal experiences with dogs.

Ask participants to consider how easily misunderstanding can occur when you are using more abstract words such as responsible, fair, independent, lonely, etc. Each person has his/her own unique perception and definition of these words. Is it any wonder that these differing perceptions can cloud, confuse, and distort communication?

You may wish to illustrate by the following example:

A supervisor might say to an aide, "You are not showing responsibility in carrying out your assignment." The aide may feel that she or he is being very responsible. The key here is how each person is defining responsibility. The supervisor may feel that "responsible" means getting all morning care done by 11:00 a.m. The aide may define "responsible" as spending more time with each client as morning care is being done, even if it delays the completion of the assignment. Until each person clarifies what their definition of "responsible" is, resolution of the conflict is unlikely to occur.

At this time you may ask if participants would like to share similar experiences that they have had with miscommunication. At the same time, ask how it was resolved and encourage the sharing of ideas by others in the group.

TIME: 15 - 20 minutes

HANDOUT #6

FACTORS INFLUENCING OBSERVATION AND PERCEPTION

1. **Physical, mental and emotional states.**

   EXAMPLE: Preoccupation with physical distress, feelings of sadness or fatigue can keep us from hearing a message. Even feeling good or excited can influence our ability to listen, as will our like or dislike for the message giver.

2. **Our senses, and their functional ability.**

   EXAMPLE: Loss of sight or hearing: A stoke or accident which causes impairment of any kind.

3. **Cultural, social and philosophical values and background.**

   EXAMPLE: Our socialization, including family traditions, religion, and social custom. Our entire belief system influences the way we perceive and interpret the world. Men embrace and give greeting kisses in some cultures. Some religions forbid work on Saturday.

4. **Personal interpretation of an event.**

   EXAMPLE: An event may evoke either "Strong" or "Neutral" feelings depending on the meaning we assign to it. Seeing a German Shepard, for instance, may cause great stress, if you had been bitten by one.

5. **The tendency to judge others on the bases of traits that are important to you personally.**

   EXAMPLE: An elderly person who is neat and clean might be held in higher esteem than one who is not if cleanliness is highly valued by you.

6. **Environmental conditions and distractions.**

   EXAMPLE: Loud noise, quiet, weather, space.

SECTION B

INTERPERSONAL STRESSORS

CONTENT:

Background Information ....pg. 19

Exercise #1 - Interpersonal Stressors ....PP. 20-24

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INTERPERSONAL

STRESSORS

Background Information:

Health care work is high stress work. Research has indicated that there are at least ten interpersonal stressors to which health care workers are especially vulnerable. They include responding to commands, taking criticism, dealing with anger, affection, depression, sexual content, pain, impulsive behavior, non-responsive behavior, and making mistakes. Responses to these interpersonal stressors are individual. What bothers one person may not bother another. When you are faced with a situation that causes you stress, however, it is very likely that even your well learned communication skills will be more at risk for breakdown. There is really not much point in learning interpersonal communication skills unless you can reduce your interpersonal stress reaction to the point where you can use the skills. Recognizing the situations that cause you the greatest stress is the first step in that process.

EXERCISE #1

IDENTIFYING

INTERPERSONAL STRESSORS

OBJECTIVE:

To assist participants in identifying interpersonal stressors that affect them negatively.

METHOD:

The attached questionnaire is distributed. Participants are instructed to estimate, on a scale of 1 - 10, the degree to which each situation causes them personal stress. A score of 10 indicates that the situation described causes a great deal of stress.

Several questions represent ten identified stressors. By calculating scores for each category, participants can determine which stressors cause the most discomfort and which cause the least.

*Instructions for calculating the scores are included on page 23.

DISCUSSION:

The trainer should emphasize that the situations will affect individuals differently. For example, some caregivers have a great deal of difficulty dealing with an angry resident while others have more trouble coping with the new resident who is depressed. Still others can handle a situation where they are criticized by a resident, but not by their supervisor.

When stress levels are high, anxiety is also high and we are more likely to become defensive in our communication in order to protect our threatened self- esteem. While this defensive posture protects us for the moment, this kind of communication does not usually resolve issues.

Finally, it is important to realize that there are times when even the most skilled communicator will experience difficulty. Usually this occurs, to a greater extent, when one is emotionally involved in a situation. The critical key is to recognize your inability to communicate constructively at that time. You may need to take a break, talk to a friend, request a change, or put some distance between you and the situation until your distress abates.

TIME: 25 - 30 minutes

INTERPERSONAL

STRESSOR INVENTORY

0	1	2	3	4	5	6	7	8	9	10
Very Relaxed			Moderately Relaxed			Slightly Tense		Moderately Tense		Very Tense

1. _____ A patient is moaning and in pain

2. _____ A patient criticizes your treatment plan

3. _____ Your supervisor gives you a command

4. _____ You say hello to a patient, but he walks by without noticing you

5. _____ You make a mistake during a patient interview

6. _____ Your supervisor has a sad look on his or her face

7. _____ Your supervisor touches your arm as he or she says warmly, "Thank you."

8. _____ Your supervisor isn't paying attention to what you are saying

9. _____ Your supervisor gives you an order

10. _____ Your supervisor criticizes your treatment plan

11. _____ A patient isn't paying attention to what you are saying

12. _____ A patient is holding her stomach and groaning in pain

13. _____ A patient tells you that she has a sexual problem

14. _____ You receive a low mark on a test

15. _____ You say hello to your supervisor, but he walks by without noticing you

16. _____ A patient acts irrationally while talking to you

17. _____ A patient gives you a stern look

18. _____ A patient says "I like you."

19. _____ A patient behaves in an impulsive way while talking to you

20. _____ You make a mistake while presenting a case at a staff meeting

21. _____ A patient gives you a command

22. _____ A patient touches your arm as his says warmly "Thank you."

23. _____ Your supervisor gives you a stern look

24. _____ Your supervisor behaves in an impulsive way while talking to you

25. _____ A patient tells you he has a sexual problem

26. _____ A patient asks you for advice on sexual intercourse

27. _____ Your supervisor frowns at you

28. _____ Your supervisor acts irrationally while talking to you

29. _____ A patient is crying

30. _____ A patient shouts at you

31. _____ The expression on a patient's face shows that he is in a great deal of pain

32. _____ A patient has a sad look on her face

33. _____ Your supervisor is crying

34. _____ A patient gives you an order

35. _____ Your supervisor shouts at you

36. _____ Your supervisor says, "I like you."

37. _____ A patient frowns at you

* Adapted from Gerrard, Boniface, and Love, Interpersonal Skills for Health Professionals

EXERCISE #1

INTERPERSONAL

STRESSORS

Instructions for Scoring Inventory

Each stressor is measured by several different statements in the survey. The score sheet (attached) indicates which statements measure the individual stressors. For example, the stressor of "commands" is measured by questions #3, 9, 21, and 34. Participants should add up their scores for all those questions. The result will be the score for how they respond to commands. If you want to be more specific, you can indicate to them that #'s 21 and 34 measure their responses to commands by residents, while #'s 3 and 9 measure their responses to commands by their supervisor, Clearly, there may be a difference in the way they respond to those two different situations. Go through the entire list of stressors making sure to allow sufficient time for participants to total their scores. The highest scores indicate the most troubling stressors. Scores will be different for everyone. It is important to emphasize that there are no right or wrong scores. This exercise is conducted merely to provide participants with an opportunity to assess the effect of various situations on their own comfort levels and, thus, performance.

EXERCISE #1 - INTERPERSONAL STRESSORS

SCORE SHEET

STRESSOR	FROM PATIENT	FROM SUPERVISOR
1. Commands	21, 34	3, 9
2. Anger	17, 30	23, 25
3. Criticism	2, 37	10, 27
4. Unresponsiveness	4, 11	8, 15
5. Depression	29, 32	6, 33
6. Impulsivity	16, 19	24, 28
7. Affection	18, 22	7, 36
8. Making Mistakes	5, 14, 20	
9. Sexual Content	13, 25, 26	
10. Pain	1, 12, 31	

SECTION C

LISTENING SKILLS

CONTENT:

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Exercise #2 - The "Hear-Q" Exercise...............pp. 29-30

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LISTENING SKILLS

Background Information:

Entire texts have been written about the technique of effective listening, testimony to the importance of this part of the communication process. Some estimates indicate that at least 45% of our communication time is spent listening. Of course, there are many different levels of listening, from passive to active. Many regard listening as a totally passive activity, not requiring much effort. This is not the case. Effective listening requires effort, skill, and, often, patience. As was indicated in an earlier section. 50% of the responsibility of accurate communication lies with the listener. There are, however, some major obstacles to effective listening.

1. Because we are able to listen at a rate several times faster than we are able to speak, we tend to think ahead of the speaker or drift off into our own thoughts.
2. Some only listen for the facts in communication, ignoring the feelings behind the words. It is important to remember that only 10% of what we communicate is with the actual words that we speak. Forty percent is conveyed by the tone of our voice and the remaining fifty percent by non-verbal communication, e.g., body language, gestures, and facial expressions.
3. Some persons experience emotional deafness when they listen. When they hear something that doesn't agree with their perception or opinion, they stop listening.
4. Some people do not listen because they are convinced that they already have all of the answers and no one else has anything meaningful to contribute.
5. Those who believe listening is a passive activity place all of the responsibility on the speaker to get the point across.
6. Some persons are so caught up in their own problems and concerns that they have little interest in what others have to say. They may look like they are listening, but their minds are on something else.

Following are a few active listening techniques that can help build listening skills:

1. Check your body language. Show that you are listening by looking at the person. Avoid distracting movements and avoid interruptions. Be aware of your facial expression. It should be changing according to the topic. Your verbal and non-verbal communication should be in harmony.

2. Try to put aside your personal "filters" and listening empathetically (from the speaker's point of view). Listen with your eyes and ears. Remember that observing non-verbal communication is as important as listening to the verbal. Listen for the feelings behind the words, i.e., a resident may tell you that he doesn't mind that his son doesn't visit, but his true feelings may be very different.

3. Be patient. Wait until the speaker has finished before you fashion your response. Silence is a very important and therapeutic communication technique. Try to overcome your discomfort with it and take the time that you need to respond. Allow the same consideration for the other person.

4. Use encouraging techniques to convey interest and keep the person talking, e.g., "I see," or "go on," or "uh huh".

5. When appropriate, restate what you heard to show your understanding, e.g., "In other words, you are saying that".

6. Use the technique of reflecting to show that you are listening and understanding how the person feels, e.g., "You were pretty upset by that.....".

7. The skill of summarizing may be used to pull thoughts and ideas as a part of the conversation comes to a close, i.e., "If I understand, you feel this way about the situation.....".

8. As the listener, you do not need to solve the problem or dilemma. Your role is to listen accurately first.

9. Pay attention to volume, pitch, and intensity of the voice.

10. Be non-judgmental in your listening. Even if you do not agree with the viewpoint of the speaker, showing disapproval will cut short the communication.

These are only a few of the skills involved in good listening. As you discuss these with participants, encourage them to expand the list.

EXERCISE #1

ACTIVE LISTENING

OBJECTIVE:

To explore the relationship between emotional investment in a topic and the ability to actively listen to another's opinion.

METHOD:

Participants are separated into groups of two. Each pair is assigned a controversial topic for discussion, e.g., gun control, abortion, acid rain, etc., and each participant within the pair is assigned responsibility for discussing the opposite side of the issue. The sequence of the discussion is as follows:

1. The first participant presents his/her side.
2. The second participant relates back to the first what he/she has heard.
3. The second participant presents his/her side.
4. The first relates back to the second what he/she has heard.

The process continues back and forth until the trainer ends the exercise. It should go on at least long enough for each person to speak, listen and report.

DISCUSSION:

People will usually comment about how difficult it was to actively listen. Comments like "I wasn't listening, I was thinking about what I wanted to say next," or "It was difficult for me to listen because I feel so strongly about this issue" are normal. Others will comment that as they used the active listening technique they found they were more in agreement with their partner than they originally thought. By really listening, a better understanding was created, narrowing the gap between the communicators. The trainer should use this opportunity to discuss how active listening might enhance relationships between themselves and residents and/or co-workers.

NOTE TO TRAINER:

Topics to be used in this exercise may relate to the health care field or may be issues of broader interest. The important thing is that the topics generate the kind of strong feeling needed to make the exercise as true to life as possible.

TIME: 25 - 30 minutes

EXERCISE #2

THE "HEAR - Q" EXERCISE

OBJECTIVE:

To provide an opportunity for participants to define the qualities of a good listener.

METHOD:

Trainer distributes the attached handout and asks participants to complete the questions. Using a flip chart, or blackboard, record the responses of the group, as they define the good listener.

DISCUSSION:

Participants, as a rule, find that they are better listeners at work than they are at home. Participants maintain, with some validity, that the closer you are emotionally to the person, the more difficult it is to maintain the role of the active listener. Others comment that they feel that listening well at work is part of the responsibility of their job and therefore mandatory.

Qualities of a good listener that should emerge during the discussions of the questions include, but are not limited to, the following:

- not judging your feelings as right or wrong
- not giving advice or trying to solve your problem
- listening attentively, eye contact, no distractions
- allowing silences when necessary
- keeping confidentiality
- helping you to clarify your own thoughts

TIME: 15 - 20 minutes

EXERCISE #2 - THE "HEAR - Q" EXERCISE

WHAT IS YOUR "HEAR - Q?"

1. On a scale of 1 to 100, how many points would you give yourself as a listener?

2. How many points would each of the following people give you as a listener, e.g., does your spouse think that you are as good a listener as you think you are?

   Your Spouse
   Your Parents
   Your Children
   Co-Workers
   Residents
   Supervisors

3. According to the above ratings, are you a better listener at home or at work?

   Why do you think this?

4. Think of one person you consider to be a good listener.

5. What, in your opinion, makes this person a good listener?

HANDOUT #1

LISTEN

WHEN I ASK YOU TO LISTEN TO ME
AND YOU START GIVING ADVICE
YOU HAVE NOT DONE WHAT I ASK.

WHEN I ASK YOU TO LISTEN TO ME
AND YOU BEGIN TO TELL ME WHY I SHOULDN'T FEEL THAT WAY
YOU ARE TRAMPLING ON MY FEELINGS.

WHEN I ASK YOU TO LISTEN TO ME
AND YOU FEEL YOU HAVE TO DO SOMETHING TO SOLVE MY PROBLEM,
YOU HAVE FAILED ME, STRANGE AS THAT MAY SOUND.

LISTEN! ALL I ASKED WAS THAT YOU LISTEN.
NOT TALK OR DO - JUST HEAR ME.
ADVISE IS CHEAP: TEN CENTS WILL GET YOU DEAR ABBY AND
BILLY GRAHAM IN THE SAME NEWSPAPER.
AND I CAN DO FOR MYSELF; I'M NOT HELPLESS.
MAYBE DISCOURAGED AND FALTERING, BUT NOT HELPLESS.

WHEN YOU DO SOMETHING FOR ME THAT I CAN AND NEED TO DO
FOR MYSELF, YOU CONTRIBUTE TO MY FEAR AND WEAKNESS.
BUT, WHEN YOU DO ACCEPT AS A SIMPLE FACT THAT I DO
FEEL WHAT I FEEL,
NO MATTER HOW IRRATIONAL, THEN I CAN QUIT TRYING TO CONVINCE
YOU AND CAN GET ABOUT THE BUSINESS OF UNDERSTANDING WHAT'S
BEHIND THIS IRRATIONAL FEELING.
AND WHEN THAT'S CLEAR, THE ANSWERS ARE OBVIOUS AND I
DON'T NEED ADVICE.
IRRATIONAL FEELINGS MAKE SENSE WHEN WE UNDERSTAND WHAT'S
BEHIND THEM.

PERHAPS, THAT'S WHY PRAYER WORKS SOMETIMES FOR PEOPLE
BECAUSE GOD IS MUTE, AND HE DOESN'T GIVE ADVICE OR
TRY TO FIX THINGS. "HE" JUST LISTENS AND LETS YOU
WORK IT OUT FOR YOURSELF.

SO, PLEASE LISTEN AND JUST HEAR ME. AND, IF YOU WANT TO TALK,
WAIT A MINUTE FOR YOUR TURN; AND I'LL LISTEN TO YOU.

ANONYMOUS

EXERCISE #3

LISTENING AND NON-VERBAL COMMUNICATION

OBJECTIVE:

To assist participants in understanding the role of non-verbal communication in active listening.

METHOD:

Participants are separated into groups of two. One participant is designated as speaker and one as listener. The speaker will need to be prepared to speak briefly on a particular topic. You may suggest a topic related to communication, resident care, etc. or they may choose a topic on their own. The topic should be one on which the participant can talk for one or two minutes.

The listeners are handed the attached instructions, but may not share them with the speaker. Once all of the participants understand the instructions, ask the speakers to begin talking.

After a couple of minutes, ask the participants to stop talking. Allow a moment or two for laughter, talk, and comment to reduce the anxiety that sometimes accompanies this type of exercise.

Ask the speakers the following questions:

1. How did you feel at the beginning of the dialogue?
2. What happened to make you feel differently as you continued to speak?
3. In what way did that interfere with what you were trying to communicate?

DISCUSSION:

Discussion will revolve around the ease with which you can talk to someone who is actively listening to what you are saying. Specifically, active listening involves maintaining eye contact, looking interested, nodding, and encouraging the speaker to go on.

Comments will also revolve around what is felt like as listeners begin to yawn, look at their watch, or otherwise act disinterested. People usually state that they felt what they were saying was not important or they no longer wished to go on speaking.

Time should be taken to reflect upon how we listen to the residents for whom we care.

What non-verbal cues do we give them that we are not really listening?

e.g., looking at our watch
changing the topic
standing, looking down at the resident
backing out the door

What non-verbal cues might be given to encourage communication?

e.g., maintaining eye contact
sitting down to speak, even if it will be only a brief encounter

Remind participants that five minutes of sincere active listening is worth more than one hour of half-listening.

TIME: 15 - 20 minutes

NOTE TO TRAINER:

Some participants may find it difficult to speak on a topic for two minutes. To minimize participants' discomfort, you may conclude the exercise after you observe that all listeners have had the opportunity to demonstrate non-listening behaviors.

INSTRUCTIONS

FOR LISTENERS

FOR THE FIRST THIRTY OR SO SECONDS, LISTEN INTENTLY TO WHAT YOUR PARTNER IS SAYING.

- MAINTAIN EYE CONTACT
- LOOK INTERESTED
- NOD, ENCOURAGE HIM/HER TO GO ON

THEN, AFTER THE THIRTY SECONDS, BEGIN TO DEMONSTRATE NON-LISTENING BEHAVIORS:

- LOOK AT YOUR WATCH
- YAWN
- LOOK BORED
- GLANCE OUT OF THE WINDOW
- SIGH

HELPING SKILLS

Background Information:

Helping skills are those used to help residents express their feelings. They are listening skills that open the door to expressions of feelings, thoughts, emotions and ideas.

The basic helping skills are ATTENDING, PARAPHRASING, CLARIFYING and PERCEPTION CHECKING. We use many of these skills daily. Each of them enhance our understanding of what we hear, or the messages that we give and receive. As caregivers, these skills are tremendously important and useful.

ATTENDING

Attending is a skill that includes eye contact, posture, gestures, and non-verbal behaviors. Attending is a way of acknowledging the feelings, ideas, and thoughts of a resident. Attending shows residents that you are interested and concerned about their feelings. In understanding and using the skill of attending, you will be able to better focus on what your resident is communicating.

EYE CONTACT

Eye contact is a very important behavior when attending or listening to your resident. The eyes are a way of making non-verbal contact with another person. Eye contact should be natural (not staring). It is important to be sincere and not force eye contact. Consider the comfort of the person to whom you are listening as you look. Observe the facial expressions that occur as you listen. Maintain a distance that is comfortable for the helper.

POSTURE

Posture is an attending behavior that shows that the helper is listening and is interested. Posture should be relaxed and comfortable. Lean slightly towards the person. If you are both sitting turn your body toward the person you are listening to. Turn your chair. If a resident approaches you and you are standing, find a place where you both can sit comfortably. If the resident is in bed, sit in a chair beside the bed where you can be seen and heard. Going for a walk with the resident may be more relaxing for both of you. Walking can release tension and reduce anxiety. Perhaps sitting outside would be appropriate. Creating a quiet and relaxed environment is part of posture.

GESTURES

Gestures communicate in a non-verbal way our understanding of messages. Inappropriate use of gestures can confuse the resident. Example of gestures are nodding or shaking of the head. Nodding can indicate agreement or understanding; shaking the head may indicate a NO in response to a question, disagreement, or perhaps "I am sorry."

Hands and how they are used give many messages. A fist may indicate anger or tension. The open hand may give the message of "I want to help." Hands are an indicator of how a person feels. We touch with our hands to sooth and to comfort. Folded hands may give the message "I am listening, or "I am relaxed." A shaking finger is used to emphasize a point or perhaps to scold.

Ask yourself what hands mean as you observe others. Notice the gestures that others make. What may the non-verbal message be? Notice the hands of the resident. They tell many stories.

VERBAL BEHAVIOR

Our words should reflect what is being said by the resident and not change the subject. The words you use indicate that you understand what you hear. By keeping your words in tune with what you hear, you show that you are listening and are hearing the correct meaning. "I see what you mean" can help residents to continue sharing their thoughts and feelings.

The tone of your voice is also important. Does it show calm and relaxed attention to the person you are listening to. It is animated when you acknowledge what you hear, or is it flat? A flat tone of voice might indicate boredom or lack of interest. Is your tone of voice one that can be heard by someone with a hearing impairment? Remember we communicate 40% of our messages through our tone of voice.

PARAPHRASING

Paraphrasing is the second helping skill. It is a way of saying to the helper what he/she has said in fewer words. It is not adding ideas of your own. It helps you to understand the meaning of what you are hearing. If you understand the meaning of what your resident says correctly it will be acknowledged or said in another way. It is important to continue this, if necessary, to fully understand what you are hearing. When listening to another person, observe for feeling words and thoughts. This skill takes practice and at times may seem artificial, yet it is very helpful. It does show that you are concerned and that you want to understand. It is a way to encourage continued openness/talking. As you continue to use it, it will become more a part of your natural ability to communicate.

PERCEPTION CHECKING

Perception is how we hear what someone else says. It is a way of checking what you hear for accuracy. It is also a way of giving and receiving feedback. It is sometimes easy to get caught up in chatter when trying to listen to someone who needs to be heard. Residents may not be comfortable sharing feelings and may not be able to express them in words. If we say "You seem to be very unhappy today," you are giving that person the opening he/she may need to share with you. It may be helpful to ask your resident to confirm that. "Are you feeling down or unhappy?" Give your resident the chance to acknowledge the feeling or the perception that you have. Let them correct it if is not accurate. Listening is the key in this skill.

CLARIFYING

Clarifying is a helping skill that clears up vague statements. You may have to guess at what the message is or ask for more information. The words used may be confusing, or go in circles. For clarification, you may say, "I am confused, I don't understand. Explain to me again what you said." It can help to restate what you heard and notice the non-verbal reactions of the resident. It may be a change in facial expression or body language.

HANDOUT #2

BASIC HELPING SKILLS

Helping Skills are those used to help individuals to express their feelings. It is a way to open the door to those feelings, emotions, ideas, and thoughts that others have. They are also known as listening skills.

ATTENDING

Using body language and gestures that show residents that you are listening and interested in what they are saying. It encourages openness and expression of feelings and ideas.

Includes: Good eye contact, leaning forward, being relaxed, nodding in acknowledgment of what is being said, paying attention, and being aware of your own facial expressions.

PERCEPTION CHECKING

Checking the accuracy of what you feel and hear. Watching for reactions.

EXAMPLE:

Resident: "I really don't want to stay in my room all of the time, but I feel I have to lately. She (new roommate) is a nice person and I want to get along with her."

Staff: "Did I hear you say you have to stay in your room?"

Resident: "Yes."

Staff: "You mentioned your roommate. Tell me about her."

Resident: "I found her in my bed. She is a sweet person, but she gets confused."

Staff: "You want to get along with her, but are upset when you find her in your bed."

PARAPHRASING

Using fewer words of your own to repeat or restate the words of the person you are listening to (not adding new ideas).

EXAMPLE:

Resident: "I miss being with my family. We spent a lot of time doing things together. I helped with the cooking and housework."

Staff: "You miss doing things with your family."

Resident: "Yes, I liked being there and helping. I feel useless now. I like to cook. I was a good one, too."

Staff: "You enjoyed cooking. It helped you feel useful."

CLARIFYING

A way of asking for further information to increase your understanding. It helps to focus on the feeling. You restate in your own words using feeling words.

Resident: "My daughter and her family don't bother with me any more. They only visit when it's convenient for them."

Staff: "You would like them to spend more time with you."

Resident: "Yes. I would, but they are so busy."

Staff: "You feel left out. Tell me more about your family. When was the last time your daughter visited?"

EXERCISE #4

HELPING SKILLS

OBJECTIVE:

To allow participants the opportunity to test their knowledge of basic helping skills (part I) and to draw on experiences to evaluate their own helping skills.

METHOD:

Participants complete the attached worksheets (parts I and II) individually, and discuss the results as a group.

DISCUSSION:

A review of the helping skills background information (pg. 34) and handout #3 is helpful for this exercise. Also, a flipchart, or blackboard, is helpful in facilitating a group discussion.

TIME: 20 - 25 minutes

EXERCISE #4 - HELPING SKILLS

PART I

I. ATTENDING

Using handout #2 as a guide, expand the following list of examples of positive ATTENDING in communication:

GOOD EYE CONTACT

NODDING IN ACKNOWLEDGMENT

1. ____________

2. ____________

3. ____________

BEING RELAXED

PAYING ATTENTION

4. ____________

5. ____________

6. ______ _____

II. PARAPHRASING

Rewrite the following statement using fewer words.

"I really do not think that I need to stay here. I need to see my daughter and tell her to take me home. There is a lot to do."

III. CLARIFYING

What words would you use to find out what the person above is really trying to say?

IV. PERCEPTION CHECKING

What question would you ask to check you perception of what is being said in the above statement?

EXERCISE #4 - HELPING SKILLS

PART II

We have all had to find someone with whom to discuss our problems. This person may have been a personal friend, a family member or a co-worker. Think about an incident in your life that was difficult and consider the following questions:

1. Did this person show concern/interest through facial expressions?

2. Do you recall what those facial expressions were?

3. Did you feel comfortable continuing your discussion or sharing your feelings and ideas?

4. Perhaps you felt that you were not heard. What did the listener do that made you feel that way?

5. Where did the discussion take place?

6. Were you relaxed?

7. What non-verbal or attending behaviors did this person use to put you at ease?

Think about your own communication skills and list below those that you feel are helpful to others.

What skills do you feel you need to work on in the future?

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UNIT #6

COMMUNICATION

OBJECTIVE	ACTIVITY	METHOD	TIME
SECTION A			
To identify aids and blockers to communication	Exercise #1 Interface in communication	Group Discussion and Handout	15-20 minutes
To discuss the role of perception in communication	Exercise #2 Perception	Group Discussion	15-20 minutes
SECTION B			
To identify which behaviors cause stress in the long-term care setting	Exercise #1 Identifying Interpersonal stressors	Individual Assessment and Group Discussion	20-25 minutes
SECTION C			
To practice active listening skills	Exercise #1 Active Listening	Group Exercise and Discussion	20-25 minutes
	Exercise #2 The "Hear-Q" Exercise	Individual Assessment and Group Discussion	20-25 minutes
	Exercise #3 Listening and Non-verbal communication	Group Exercise and Discussion	15-20 minutes
To test participants' knowledge of helping skills	Exercise #4 Helping Skills (Parts I and II)	Self Assessment and Group Discussion	20-25 minutes

GLOSSARY

G.E.& R.O. MANUAL

ACTING OUT: Behavior that occurs as means of expressing feelings. It may be acceptable (crying when sad) or unacceptable, even destructive (throwing chairs or hitting another person when angry).

ACTIVE LISTENING: The skill of attending carefully to what another person says and conveying this attention with posture, eye contact, facial expressions, and sometimes words.

ACALCULIA: Loss of the ability to do arithmetic calculations.

ADAPTIVE MECHANISM: (Coping or defense mechanisms). Learned behaviors that assist an individual to adjust to the environment.

AFFECT: The outward display of a person's feelings.

AGEISM: Tendency to impose limitations or expectations related solely to chronologic age.

AGGRESSIVE BEHAVIOR: Behavior that is violent or destructive ranging from threatening verbalizations to striking other persons or throwing objects. This behavior is often associated with anger, hostility or intense fear.

AGITATION: An anxiety associated with severe motor restlessness.

AGRAPHIA: Loss of ability to write.

AGNOSIA: Loss of auditory, sensory, or visual comprehension.

AKATHISIA: A side effect of antipsychotic medication that is manifested by a feeling of restlessness, frequently accompanied by complaint of a twitching or crawling sensation in the muscles.

ALZHEIMER'S DISEASE: An organic mental disorder characterized by cerebral atrophy, plaque deposits in the brain, and enlargement of the third and fourth ventricles. It results in loss of speech and motor function, profound changes in behavior and personality, and death.

AMBIVALENCE: Presence of strong and often overwhelming simultaneous contrasting attitudes, ideas, feeling, and drives toward an object, person, or goal.

ANXIETY: Feelings of apprehension when there is a threat to self-esteem, value, or belief.

APHASIA: Loss of the ability to speak or understand language.

APATHY: A seeming lack of feelings or emotional response; apparent indifference to surroundings, circumstances, or situations.

ASSERTIVENESS: Behavior that allows a person to stand up for rights, get needs met, and express feelings while not controlling or exploiting another; standing up for your rights without hurting another person.

BASIC HUMAN NEEDS: Those things humans require to maintain physiologic and psychologic homeostasis.

BEHAVIOR: Anything that a person does or says.

BEREAVEMENT: Suffering from loss of a loved one by death, characterized by grief and mourning.

BLOCKING: An interruption in the flow of speech due to the intrusion of distracting thoughts.

BODY IMAGE: The individual's perception of his or her physical self.

BODY LANGUAGE: The transmission of a message by body position or movement.

CATASTROPHIC REACTION: Disintegration of behaviors and thoughts, bordering on panic; induced when demands exceed one's coping capacity. Reaction is characteristic of persons with organic mental disorders when exposed to taxing situations.

CATATONIC: A state of psychologically induced immobilization at times interrupted by episodes of extreme agitation.

CLANG ASSOCIATIONS: A speech pattern characterized by rhyming.

COGNITION: The process of knowing, including judgment and awareness.

COGNITIVE: Referring to processes such as remembering, thinking, perceiving, abstracting, and generalizing.

COMMITMENT: Involuntary admission in which the request for hospitalization did not originate with the patient. When he is committed, he loses the right to leave the hospital when he wishes. It is usually justified on the grounds that the patient is dangerous to self or others and needs treatment.

COMMUNICATION: Exchange of thoughts, ideas, or feelings between two or more people.

COMPULSIVE BEHAVIORS: Ritualistic acts, usually repetitive and purposeless in nature, used in an effort to deal with anxiety or unacceptable thoughts.

CONFABULATION: Fabrication of stories in response to questions about situations or events that are not recalled.

CONFUSION: A mental state in which a person appears bewildered and makes inappropriate statements and answers to questions.

CULTURE SHOCK: The shock that can occur when an individual changes quickly from one social setting to another where former patterns of behavior are often ineffective.

DEFENSE MECHANISM: An unconscious process that functions to protect the self or ego from anxiety; a coping mechanism.

DELIRIUM: An acute, reversible, organic mental disorder characterized by bewildered, restless, confused, disoriented behavior associated with fear or hallucinations.

DELUSION: A fixed, false belief that has no base in reality.

DELUSIONS OF GRANDEUR: An exaggerated concept of one's importance, power, knowledge, or identity.

DEMENTIA: A progressive, deteriorating condition caused by organic brain pathology, characterized by losses in the areas of memory, judgment, affect, orientation, and comprehension.

DEPRESSION: An affective state characterized by feelings of sadness, guilt, and low self-esteem, often related to a loss.

DIPLOPIA: Double vision.

DISENGAGEMENT: Term used to describe the mutually desirable withdrawal of society and aged individuals from dynamic interchange.

DISORIENTATION: A state in which the individual has lost the ability to recognize or determine his or her position with respect to time, place, and/or identity.

DRUG HOLIDAY: Discontinuing a drug for a limited period of time to evaluate baseline behavior and to control the dosage of psychoactive drugs and side effects.

DYSARTHRIA: Difficulty in speech production as a result of incoordination of speech apparatus.

DYSPHASIA: Difficulty speaking.

DYSTONIA: A side effect of antipsychotic medication that is characterized by muscle spasms, particularly of the head, neck, and tongue.

ECHOLALIA: The repetition by a person of words addressed to him or her.

EGO BOUNDARIES: An individual's perception of the boundary between himself and the external environment.

EMPATHY: Seeing or feeling a situation the way another person sees or feels it.

ETIOLOGY: The cause.

EUPHORIA: A heightened feeling of psychological well-being inappropriate to apparent events.

EXTRAPYRAMIDAL EFFECTS: (EPS): Side effects of an antipsychotic medication that resemble the symptoms of Parkinson's Disease, including tremor, drooling, and altered gait.

FLIGHT OF IDEAS: Rapid verbalizations with is a shifting from one idea to another.

GERONTOLOGY: The study of all aspects of aging.

GRIEF, GRIEVING, GRIEF WORK: Behavior associated with mourning a loss, whether observable or perceived. It can be viewed as tasks necessary for adaption to the loss, e.g. identification of loss, expression of related feelings, making lifestyle changes that incorporate the loss.

HELPING RELATIONSHIP: A relationship in which one person seeks another for understanding, comfort, advice, or recommendations for possible action.

HOLISTIC: Viewing the person as a whole, with all aspects of functioning interrelated; especially seeing mental and physical health as interrelated.

HOMEOSTASIS: The body's tendency to maintain a steady state despite external changes; physiological "staying power."

IDEAS OF REFERENCE: Misinterpretations of events or situations in which the individual believes the event has direct reference to him or herself when it does not.

INCOMPETENCY: A legal status that must be proved in a special court hearing. As a result of the hearing the person can be deprived of many of his civil rights. Incompetency can be reversed only in another court hearing that declares the person competent.

INSIGHT: Understanding or self-awareness that occurs when connections between conscious behavior and feelings, desires, or conflicts are recognized.

INTERVENTION: Activities performed by the nurse and the patient to change the effect of a problem.

ISCHEMIA: Lack of blood supply to a body part.

KINESTHESIA: The sense of awareness of the position and the movement of the body parts.

LIBIDO: The urge or desire for sexual activity; also called sex drive and sexual motivation.

LIVING WILL: A statement of a person's wish not to be kept alive by artificial means or "heroic measures."

LOOSE ASSOCIATIONS: A symptom of disordered thought processes in which successive ideas are expressed in an unrelated or only slightly related manner.

MANIC BEHAVIOR: Hyperactive behavior characterized by excessive response to stimuli, push of speech, short attention span, lack of impulse control, low frustration tolerance, inability to impose internal controls, and possibly aggressive and/or self-destructive actions.

MENTAL WELL BEING: A state of contentment, peace of mind, and satisfaction with living and life.

MOTIVATION: Desire.

MOURNING: The process through which grief is eventually resolved or altered.

OBSESSIVE THOUGHTS: Ideas that occupy the individual's time and energy to the point of interfering with daily life. The thoughts are often ruminative, deprecatory, or persecutory in nature.

ORIENTATION: Awareness of time, place, and person.

ORGANIC DISORDER: A mental or emotional impairment that is believed to be physiological in origin.

PANIC: An attack of extreme anxiety that involves the disorganization of the personality. Distorted perceptions, loss of ration.

PARAPHRASING: Restating a person's message, thought and/or feelings, using similar words.

PATIENT ADVOCATE: A person who speaks on behalf of a patient and can intercede on the patient's behalf.

PERCEPTION: The process of understanding something new and then making it part of one's previous experience or knowledge; a person's awareness and identification of a person, thing or situation.

PERCEPTION CHECKING: Verifying the accuracy of listening skills by giving and receiving feedback about what was communicated.

PERSONAL SPACE: The physical distance people prefer to maintain in their interactions with others.

PICA: A craving for unnatural foods, often during pregnancy, some psychologic conditions, or extreme malnutrition.

POWERLESSNESS: Perceived lack of control over events.

PRESSURE OF SPEECH: An increase in the amount of spontaneous speech; rapid, loud, accelerated speech.

PRECIPITATING FACTOR: A situation or factor of importance to the client that is related to the development of an unhealthy response. It may be a major event, e.g. death, loss or something that may seem minor to others.

PRESENILE DEMENTIA: A general category of organic mental disorders involving progressive behavioral and personality changes due to primary degeneration and loss of brain neurons in people under age sixty-five.

PSYCHIATRY: The branch of medicine that treats behavioral, emotional or mental disorders.

PSYCHOGENIC PAIN: Pain caused by psychologic factors.

PSYCHOLOGY: The study of mental processes and behavior.

PSYCHOMOTOR: Referring to motor actions related to cerebral or psychic activity.

PSYCHOMOTOR RETARDATION: Slowing of mental and physical activity.

PSYCHOSOMATIC: Concerning the mind and the body; emotional disturbances manifested by physiologic symptoms.

PSYCHOTIC BEHAVIOR: A dysfunctional state in which the individual is unable to recognize reality, communicate effectively with others, and/or exhibits regressive or bizarre behavior. Reduced level of awareness. Has great difficulty functioning adequately.

RESISTIVE BEHAVIORS: Behaviors that inhibit involvement, cooperation or change.

RITUALISTIC BEHAVIOR: (Ritualism): A series of repetitive acts performed compulsively, often to relieve anxiety.

SCHIZOPHRENIA: A manifestation of anxiety of psychotic proportions, primarily characterized by inability to trust other people and disordered thought processes, resulting in disrupted interpersonal relationships.

SELF-ACTUALIZATION: (Maslow). The highest level of personality development.

SELF-CONCEPT: The combination of beliefs and feeling one holds about oneself at a given time.

SELF-ESTEEM: The degree to which an individual feels valued and worthwhile as a person.

SELF-IMAGE: A person's perception of self at a specific time or over a period of time.

SENESCENCE: The process of growing old.

SENILE: Term pertaining to the supposed characteristics of old age, particularly mental infirmity; often used in a disparaging manner.

SENSORY DEPRIVATION: Insufficient sensory stimulation for a person to function.

SEXUAL IDENTITY: A person's inner feeling or sense of being male or female.

STEREOTYPE: Something that conforms to a fixed pattern; an oversimplified judgement or attitude about a person or group.

STRESSOR: Any factor that produces stress or alters the body's equilibrium.

SUPPORT SYSTEM: The people and activities that can assist a person at a time of stress.

TARDIVE DYSKINESIA: Descriptive term for abnormal movements of mouth, tongue, maxilla, and mandible as a result of a long-term use of certain drugs, particularly of some major tranquilizers.

THOUGHT BROADCASTING: Feeling that one's thoughts are being heard or projected into the environment.

THOUGHT DISORGANIZATION: A mental condition evidenced by difficulty remembering what one is saying, confusion about time, inappropriate verbal responses, and sensory distortions.

VALUE: Something of worth; a belief held dearly by a person.

VALUES CLARIFICATION: A process by which individuals define their own values.

VOLUNTARY ADMISSION: A type of admission to a psychiatric hospital in which the individual applies in writing and agrees to receive treatment and abide by the hospital rules. If the patient wishes to be discharged, he must give written notice to the hospital.

WAXY FLEXIBILITY: A condition in which the client's extremities are easily moved by another person, but remain rigidly in the position in which they are placed, no matter how awkward or uncomfortable the position.

WORD SALAD: A combination of words and phrases commonly seen in schizophrenic states which lack meaning or coherence.